2000-12

Military healthcare reform and legislative changes for FY01

Richardson, Timothy R.

Monterey, California. Naval Postgraduate School

NAVAL POSTGRADUATE SCHOOL
Monterey, California

THESIS

MILITARY HEALTHCARE REFORM AND LEGISLATIVE CHANGES FOR FY01

by

Timothy R. Richardson

December 2000

Thesis Advisor: Richard B. Doyle
Associate Advisor: Frank J. Barrett

Approved for public release; distribution is unlimited.

REPORT DOCUMENTATION PAGE

Form Approved
OMB No. 0704-0188

1. AGENCY USE ONLY *(Leave blank)*	2. REPORT DATE December 2000	3. REPORT TYPE AND DATES COVERED Master's Thesis

4. TITLE AND SUBTITLE: Military Healthcare Reform and Legislative Changes for FY01

5. FUNDING NUMBERS

6. AUTHOR(S)
Richardson, Timothy R.

7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES)
Naval Postgraduate School
Monterey, CA 93943-5000

8. PERFORMING ORGANIZATION REPORT NUMBER

9. SPONSORING / MONITORING AGENCY NAME(S) AND ADDRESS(ES)

10. SPONSORING / MONITORING AGENCY REPORT NUMBER

11. SUPPLEMENTARY NOTES
The views expressed in this thesis are those of the author and do not reflect the official policy or position of the Department of Defense or the U.S. Government.

12a. DISTRIBUTION / AVAILABILITY STATEMENT
Approved for public release; distribution is unlimited.

12b. DISTRIBUTION CODE

13. ABSTRACT *(maximum 200 words)*

Healthcare is considered one of the most important non-cash benefits in the military compensation package. However, the Military Healthcare System (MHS) has several significant problems, including inequity in benefits, lack of access to care, growing out-of-pocket cost, and a perceived "promise" of free healthcare for life for military retirees that has not been kept. This thesis examines the MHS and congressional reforms during the 2nd session of the 106th Congress addressing these problems. An expanded background of the MHS benefit is presented, followed by a description of current problems with the MHS. Recommended DoD reform initiatives are reviewed, along with bills addressing MHS initiatives. Changes to the military healthcare benefit passed for FY01 are documented and explained. The research methodology included a review of public records, websites, congressional testimony, reports from relevant congressional committees, JCS, OSD, and DoD healthcare reform proposals, and phone interviews with military healthcare experts. A major new entitlement called TRICARE-For-Life and a retiree pharmacy program were enacted, representing the largest increase in domestic spending in over 30 years to address problems with the MHS.

14. SUBJECT TERMS
Healthcare, Military Healthcare, MHS, DoD Health Programs, TRICARE, Medicare, Healthcare reform, MHS Reform.

15. NUMBER OF PAGES
98

16. PRICE CODE

17. SECURITY CLASSIFICATION OF REPORT	18. SECURITY CLASSIFICATION OF THIS PAGE	19. SECURITY CLASSIFICATION OF ABSTRACT	20. LIMITATION OF ABSTRACT
Unclassified	Unclassified	Unclassified	UL

NSN 7540-01-280-5500

Standard Form 298 (Rev. 2-89)
Prescribed by ANSI Std. 239-18

Approved for public release; distribution is unlimited

MILITARY HEALTHCARE REFORM AND LEGISLATIVE CHANGES FOR FY01

Timothy R. Richardson
Lieutenant, Medical Service Corps, U.S. Navy
B.S., Park College, May 1991
M.S., Troy State University, August 1994

Submitted in partial fulfillment of the
requirements for the degree of

MASTER OF SCIENCE IN MANAGEMENT

from the

NAVAL POSTGRADUATE SCHOOL
December 2000

Author: [redacted]
Timothy R. Richardson

Approved by: [redacted]
Richard B. Doyle, Thesis Advisor

[redacted]
Frank J. Barrett, Associate Advisor

[redacted]
Reuben T. Harris, Chairman
Department of Systems Management

ABSTRACT

Healthcare is considered one of the most important non-cash benefits in the military compensation package. However, the Military Healthcare System (MHS) has several significant problems, including inequity in benefits, lack of access to care, growing out-of-pocket cost, and a perceived "promise" of free healthcare for life for military retirees that has not been kept. This thesis examines the MHS and congressional reforms during the 2nd session of the 106th Congress addressing these problems. An expanded background of the MHS benefit is presented, followed by a description of current problems with the MHS. Recommended DoD reform initiatives are reviewed, along with bills addressing MHS initiatives. Changes to the military healthcare benefit passed for FY01 are documented and explained. The research methodology included a review of public records, websites, congressional testimony, reports from relevant congressional committees, JCS, OSD, and DoD healthcare reform proposals, and phone interviews with military healthcare experts. A major new entitlement called TRICARE-For-Life and a retiree pharmacy program were enacted, representing the largest increase in domestic spending in over 30 years to address problems with the MHS.

TABLE OF CONTENTS

LIST OF TABLES

I. INTRODUCTION

A. PURPOSE

Military healthcare reform initiatives were a priority for the 106th Congress, as the Joint Chiefs of Staff (JCS) declared the year 2000 to be "the year of military healthcare reform" [Ref. 1]. Healthcare is considered one of the most important non-cash benefits in the military compensation package [Ref. 2:p. 11].

However, criticisms from beneficiaries have grown, on such issues as the inequality in healthcare benefits, lack of access, growing out-of-pocket cost, and DoD's willingness to keep the "promise" of free healthcare for life. Each problem has potential negative impacts on recruiting, retention and morale in the armed services.

The Military Health System (MHS) and the benefits it provides are inherently very complicated and expensive. To correct or remedy the problems may require a very expensive reform package.

The primary objective of this research is to examine reform to the MHS by the 106th Congress and DoD. Specifically, this thesis will track changes made to the MHS and the impact of these budgetary changes.

B. RESEARCH QUESTIONS

The primary research question in this thesis is how did Congress address military healthcare reform for FY01?

Secondary questions addressed include:

What are the current healthcare policies concerning TRICARE benefits, retiree benefits and active duty benefits?

How did the Clinton Administration propose to change military healthcare in the FY01 budget submission?

What were the policy and budget changes made by the defense budget committees during the FY01 budget cycles?

What did the lobby groups propose to change in military healthcare for FY01?

What was the impact of the final congressional action on military healthcare in the FY01 budget?

C. SCOPE

This thesis will review past and current military healthcare policies, document the need for changes to the current system, identify proposed reform initiatives, track the MHS benefit from the President's budget to the authorization and appropriation bills, and analyze impacts of policy and budgetary changes considered and implemented in 2001.

D. BACKGROUND

To put this thesis in perspective, the background of the MHS will be described. This section will include active duty, active duty dependents, retiree and retiree dependents' benefits, and current demographics of the MHS. Finally, the next section will identify some problems with the MHS and why reform was thought to be necessary.

This chapter is essential in laying the groundwork for why the DoD and the President recommended reform, and why the House, Senate and lobbyist groups pushed for changes to the MHS in 2000.

To fully understand the MHS, its origins and the cause of its current policies need to be understood. The MHS began administering health care in 1799, with the passage of legislation that "established that active duty and retired personnel of the Navy and Marine Corps would have deducted from their pay a sum of twenty cents per month to provide for their care if they became sick or disabled" [Ref. 3:p. 2 and Ref. 4:p. 3]. Prior to this, care was provided only for the "regimental sick" and the "relief of sick and disabled seamen." Healthcare was provided "free of charge" to active-duty members. Dependents of both (and all other retirees) were required to pay all costs and seek medical care from the civilian health care system.

In 1884 the "Appropriations Act for the Army" passed, allowing Army Medical Officers to treat families of active duty "free of charge." This Act was Army specific due to the lack of medical care surrounding the "scattered" forts of the western frontier [Ref. 5:p. 13 and Ref. 6]. The Navy and the Marine Corps having ready access to available dependent care due to well-populated major ports, continued to purchase dependent care from civilian sources.

In 1899, a new law was passed to "reorganize" and "increase the efficiency" of the Navy and Marine Corps personnel. This law was interpreted to mean that Navy Medical Officers could provide health care to Navy and Marine Corps dependents in a similar fashion to what the Army was doing [Ref. 3:p. 4 and Ref. 7]. Both the Act in

1884 and the Act in 1899 indicated that it was acceptable for active-duty dependents to be seen by military health care providers if "no other provision is made" and "whenever practical" [Ref. 5:p. 14].

However, these acts did not provide for the care of retired military or their dependents. Navy and Marine Corps retirees still had money deducted from their pay to help pay for health care, while other military retirees and all retiree dependents continued to purchase their own health care from non-military sources.

Dependent care was again addressed in 1943 by "An Act to Provide for the Expansion of Navy Medical Facilities." This Act provided the first real definition of a "dependent," as follows:

> "Changes in the law have molded the definition of a "dependent" to be "A person who bears one of the following relationships to an active duty member, to a retiree," "or to a deceased person who at the time of death, was an active duty member or retiree." Basically this includes; a lawful wife, or husband, an unremarried widow, or widower, an unmarried child (including an adopted or stepchild), if such a child has not passed their twenty-first birthday, a parent or parent-in-law, if in fact dependent on the member or retired member for over one-half of their support, and residing in the household of member or retired member, or an under twenty-three year old enrolled in a full time institution of higher learning, and an unmarried child incapable of self support" [Ref. 8 and Ref. 9].

It also limited dependent care to inpatient and emergency care covering "only acute medical and surgical conditions" [Ref. 3:p. 5 and Ref. 10].

This narrowing of the definition applied only to the Navy and Marine Corps. Medical care provided to active-duty dependents continued to meet the previous

conditions of if "no other provision is made," meaning it was not readily available in the civilian community.

Based on these facts, we are led to believe that most dependents sought and still paid for medical care from civilian providers. There was as yet no official action or stance on the care provided to retirees or their dependents.

Subsequent attempts were made to introduce into law new dependent care bills, but no significant legislation passed until the 1956 "Dependent's Medical Care Act" [Ref. 11]. The overarching purpose of this Act was "...to create and maintain high morale in the uniformed services by providing an improved and uniform program of medical and dental care for members and former members of those services and their dependents" [Ref. 11]. This important piece of legislation officially stopped the deduction of money for healthcare from Navy and Marine Corps active and retired personnel and allowed all active duty dependents and retired and their dependents to use Military Treatment Facilities (MTFs) on a space available (space-A) basis. Space-A means they could receive care if the MTF was capable of providing it and had the available space and resources to provide the care. Charges for active duty dependents, retirees and their dependents for inpatient visits at MTFs were added.

A "spouses and children" insurance plan was adopted which gave active duty dependents the option of going to the MHS or a civilian facility accepting the insurance provisions of the law. The insurance plan had small charges associated with the care provided. Maternity care was provided free of charge from civilian sources but was later

changed to charge the same as any other care provided by civilians. This legislation only addressed inpatient care and very limited outpatient services.

Congressional concern was high in 1958 over the increasing number of dependents and retirees and the cost of the civilian care for them. They knew the cost was high for civilian care and they wanted to ensure the MHS was operating at capacity. The intent of Congress was to save money by providing all possible care in the military direct care system (using MTFs and military clinics).

In response to congressional pressure, the Secretary of Defense issued a directive ordering "rigid restrictions on the use of Medicare by dependents," and for all dependents and retirees to "utilize uniformed services medical facilities if available and adequate" [Ref. 3:p. 16]. The directive also required dependents to get a "non-availability" statement from their local MHS commander before they were authorized to seek and receive civilian care.

In 1964, a House Armed Services Subcommittee issued a report stating that the government did indeed have an obligation to provide medical care to military personnel and to their dependents, based on their service to their country. The report also stated "it is clear to the Subcommittee that in future years a major portion of care must come from civilian facilities if it becomes governmental policy to provide such care" [Ref. 3:p. 20].

As a result of this report and other studies, possibly the most critical and controversial bill, the "Military Medical Benefits Amendments of 1966," was passed. This law contained provisions that provided free "space-A" outpatient care for active-

duty dependents with a co-pay if the care came from a civilian source, provided for civilian inpatient and outpatient care for retirees and their dependents (identical to active-duty dependents), and specified that "all retirees would lose their eligibility for such medical care at age 65" when they become eligible for Medicare [Ref. 12]. The "Military Medical Benefits Amendments of 1966" officially reversed the 1958 decision to bring retirees and dependents over the age of 65 into the MHS to save money. The MHS had the discretion to continue to treat these (eligible for space-A) beneficiaries as long as space and facilities were available and the medical staffs were capable [Ref. 12].

The previously mentioned "spouses and children" insurance plan of 1956 and the "Military Medical Benefits Amendments of 1966" together became known as the Civilian Health and Medical Program for Uniformed Services (CHAMPUS) in 1966 [Ref. 13:p. 8]. CHAMPUS's intent was to provide services to active duty dependents and retirees and their dependents, on a deductible, co-pay, and cost-share basis. Essentially, CHAMPUS was established to augment the MTF, rounding out what became known as the MHS in the late 1990's [Ref. 13:p. 8].

CHAMPUS and the MTFs had minor changes in fees charged, dependent status and benefits available between 1966 and 1996. During the Cold War and the Reagan build-up, the MHS was designed to be capable of supporting multiple scenarios consisting of mass casualties in a European theater of war. Consequently, the peace dividend was a MHS capable of and in need of training for handling large numbers of patients. The MHS provided care to all eligible beneficiaries due to its size and need to

keep providers proficient. However, present day scenarios, as defined in the 1997 Quadrennial Defense Review, require far less capacity [Ref. 2:p. 11 and Ref. 14].

1996 marked the advent of TRICARE, the DoD's current managed health care plan (described below). Based on the mission of the MHS, as stated by Lane and Melody, "the DoD maintains a medical establishment for three separate but united reasons" [Ref. 15]. The three reasons they refer to are first and most important, the wartime mission; "To meet wartime demands for medical care in a scenario defined by nearly two simultaneous major regional conflicts" [Ref. 15]. This is the original and basic underlying purpose of the MHS, to keep active forces well during conflict.

The second reason for the MHS is for day-to-day operational support. This benefit is to keep our active duty military healthy in a peaceful environment to be prepared for conflict. Day-to-day operational support provides care to 1.5 million active-duty military [Ref. 15].

Finally, the MHS supports the peacetime health benefit. This health benefit provides inpatient and outpatient care to the eligible beneficiary population of about 8.1 million, including the fastest growing population of over 350,000 over-65 year old beneficiaries [Ref. 16].

The current mission of the MHS, as stated by the Congressional Budget Office, is "to keep service members ready for duty and provide them with care during military operations" [Ref 2:p. 11]. In 2000, these health care benefits have an annual cost of

approximately $17 billion [Ref. 16]. The health care benefit is often considered the most important to the military member in his/her decision to join or stay in the military.

The present day MHS provides health care to active duty personnel free through its direct care system (78 DoD hospitals, 495 clinics, and a network of civilian providers) [Ref. 17]. All other beneficiaries, except those who are 65 and over, have the choice of three avenues for receiving health care.

First is to enroll in TRICARE Prime and receive treatment through the same (or very similar) direct care system used by active duty military personnel. Beneficiaries that choose this option have little flexibility because they have a chosen provider they must use, but no or low fees or co-pays for care received [Ref. 15].

The second choice is called TRICARE Extra. It is a plan that allows beneficiaries to choose from a large number of civilian providers featuring co-payments and deductibles similar to a preferred provider or fee-for-service plan [Ref. 15].

Under the third option, called TRICARE Standard, (essentially replacing the old CHAMPUS program, and also available to TRICARE Extra patients) beneficiaries can receive care using the direct care system at very little or no cost on a space-A basis [Ref. 15].

Upon reaching the age of 65, MHS beneficiaries become eligible for Medicare and are no longer authorized to use TRICARE. These Medicare-eligible beneficiaries

may only use MHS facilities for free prescriptions, laboratory services, and the much-coveted space-A care [Ref. 2:p.11].

E. PROBLEMS WITH THE MHS

A number of problems have been identified within the current MHS. Discontent has grown among beneficiaries, as noted by organized political groups representing the retirees, complaints from active-duty members and their dependents, and low recruiting and retention among active-duty members [Ref. 17:p. 2].

The first problem with the MHS is the change in its demographic population. There is a large and growing retiree population conflicting with a shrinking MHS and active duty population. The changing demographics create a greater demand for certain specialty services. Active-duty military and their dependents tend to be younger and healthy. In contrast, the over-65 population is inherently sicker and in need of much more medical attention. The MTFs cannot see all retirees, but providers need the over 65 population caseload to stay proficient in these specialty areas of healthcare [Ref. 18:p. 9]. This change in demographics was caused by the active-duty military force being cut by 40 percent since 1989, leading to a dependent and retiree population outnumbering the active-duty by more than 4-to-1 [Ref. 19:p. 4].

Another problem concerns the retiree healthcare inequity. Military retirees do not have a healthcare program that is comparable to the program for civilian retirees from the federal government [Ref. 18:p. 9].

A third issue is centered on the claim by Medicare-eligible retirees and their over 65 dependents that the DoD has reneged on a promise to provide "free healthcare for life." This was construed as a perception of a "broken promise" to retirees. These beneficiaries are the only federal government personnel who have been prevented from using their employer-provided healthcare at or over age 65 [Ref. 4:pp. 3,9].

A fourth problem concerns the quality of the benefit provided by the MHS. Poor healthcare is considered a major quality of life problem. Quality healthcare is a critical aspect of the quality of life for military members, and consequently affects recruiting and retention [Ref. 4:p. 9]. The availability of quality lifetime healthcare is a crucial recruiting and retention tool for the military [Ref. 4:p. 9].

Funding represents a fifth problem. The Defense Health Program (DHP) has trouble planning for and controlling healthcare cost. Making healthcare planning worse, the projected healthcare budgets through 2007 may be unfunded by more than $3 billion [Ref. 20:p. 2].

The sixth issue is a lack of uniform TRICARE coverage. TRICARE has five different contractors operating in twelve administrative locations, each one with a different contract and benefit coverage [Ref. 18:p. 6]. Administrative "red tape", cost saving tactics, and poor communication between MTFs and TRICARE contractors create hassles and problems for beneficiaries. The more costs are scrutinized, the more Bureaucratic "red tape" is installed to control the systems creating different coverage [Ref. 18:p. 10].

A seventh issue is the Medicare pharmacy inequity. Medicare does not provide prescription drug coverage to its beneficiaries, while MHS eligible beneficiaries residing close to an MTF can receive prescription drugs for free. This inequity is considered one of the most expensive out of pocket expenses [Ref. 19:p. 11].

An eighth issue concerns billing and payment problems involving TRICARE and the MHS. Low reimbursement rates, slow payments to doctors from TRICARE, and slow MHS payments to the TRICARE contractors have created problems for the beneficiaries. These problems include delays in treatments, loss of civilian providers, and delays in care provided to patients [Ref. 18:p. 11, and Ref. 19:p. 14].

A ninth concern is poor access to healthcare. Those at remote locations, those subjected to very limited space-A, and those with no MTF within close proximity suffer the most by a lack of available healthcare [Ref. 20:p. 2, and Ref. 4:p. 9, and Ref. 19:p. 14].

Inequality in the cost of benefits to beneficiaries is a tenth issue. If a beneficiary uses an MTF, treatments are free. However, health services provided by civilian facilities have a co-pay, and for some beneficiaries (under 65), a large enrollment fee and co-pays [Ref. 20:p. 2, and Ref. 19:p.4].

Finally, there is a continuing debate over the size of the MHS. Three services are providing similar, and at times redundant, healthcare roles for a shrinking active-duty population. The MHS is based on a doctrine that was well suited to meet the "demands

of major mobilization and wartime conditions", but is no longer suited for the current size of the MHS [Ref. 19:p. 14 and Ref. 2:p. 18].

Too much healthcare reform could disrupt the balance between wartime readiness and peacetime welfare. If too much medical capability is out-sourced or diminished, the medical mission will not be met. Reforms must be balanced among quality of life issues, readiness demands, and peacetime needs [Ref. 18:p. 11].

Given the scope and complexity of the problems affecting the MHS, it is highly unlikely that healthcare reform legislation will be passed satisfying all or even most of these problems. Indeed, the reforms undertaken in 2000 did not even address all of the problems. Furthermore, limited resources mean that some reforms will not be affordable. The DoD budget is a zero-sum game, where one program's increase in funding comes at the expense of another.

The Chief of Naval Operations (CNO), Admiral Clark, made it clear he wants top priority given to readiness issues [Ref. 21]. Funding for the Defense Health Program (DHP) competes directly with weapons systems and operations and support, making funding of healthcare reform most likely coming from cuts in non-defense programs, new taxes or another DoD quality of life program.

This thesis will describe proposed reform initiatives, the target populations, estimated cost and the basis for the reform. Included will be the President's Defense Health Program budget, House, and Senate proposals. The Budget Resolution, and the authorization and appropriation bills will then be discussed. The research will close with

a summary of its chapters, a summarization and analysis of MHS reform passed, areas the healthcare reform neglected, and recommendations for future research.

II. THE PRESIDENT'S BUDGET PROPOSAL FOR MILITARY HEALTHCARE

A. DoD AND THE JOINT CHIEFS OF STAFF (JCS) PROPOSALS

In response to recent legislation and MHS concerns to modernize, implement cost saving measures and to streamline the health services, the Surgeons Generals and the DoD in 1998 considered 29 separate reform initiatives [Ref. 19:p. 6]. The main focus of these reforms was to satisfy readiness needs and optimize peacetime healthcare. Examples of the initiatives include pharmacy management, outsourcing functions, improved information systems, increasing access to appointments and centralized purchasing. Though these initiatives may prove to be effective, they tend to have high start up costs. In light of the estimated 225 percent increase in healthcare cost the DoD has experienced from 1980 to 1990, the cost issue may prove to be the most significant [Ref. 19:p. 4].

Legislation passed in the 1990s has initiated demonstration projects targeted at improving care and identifying cost associated with retirees. The first major demonstration project is known as Medicare Subvention. Also known as Senior Prime, this project lets the DoD administer healthcare to Medicare-eligible beneficiaries and charge the Health Care Financing Association (HCFA) for reimbursement. The Medicare Subvention demonstration project has been plagued by accusations of a controlled selection of demonstration sites based on weak statistical demographic representation and

low enrollment and rates of reimbursement, indicating that it is a bad proposition for the DoD [Ref. 19:p. 7].

A second demonstration project is the Federal Employees Benefits Program (FEHB) demonstration. This gives Medicare-eligible beneficiaries access to the same health plans as federal civil service retirees, including the cost of the premiums. Bad marketing, high premiums, and the temporary status of the project caused very low enrollment. Projected (estimated) costs are as high as $10 billion per year [Ref. 19:p. 9].

A third program being tested is the Pharmacy Pilot project. Under this program, Medicare-eligible retirees can obtain prescription drugs through DoD's mail order program or network of retail pharmacies. Medicare currently does not provide coverage for prescription outpatient drugs (a major expense for older people). The DoD has a mail order pharmacy benefit that provides prescription drugs to all beneficiaries except the Medicare-eligible. Only Medicare-eligible beneficiaries who can physically visit a military pharmacy have this benefit. The pilot project has enrollment fees and co-pays, depending on whether medicines are obtained via mail or a retail pharmacy. The estimated cost for this project is between $400 and $600 million annually [Ref. 19:p. 11].

Finally, there is the TRICARE Senior Supplement project. Under this program Medicare-eligible retirees can use TRICARE Standard and Extra to supplement Medicare (including prescription drug coverage). These beneficiaries will also have a benefit similar to the one available under the Pharmacy Pilot project. This project is a supplement to Medicare at approximately one third the cost of other standard Medicare

supplemental policies. This benefit may cost as much as $650 million per year [Ref. 19:p. 11].

These and a few other legislative approved projects are still relatively new. Conclusive evidence as to beneficiary acceptance, costs, and program management has not yet been established. But they were the groundwork and launching points for the JCS's proposals to the President for inclusion to his budget [Ref. 19:pp. 6,7].

The JCS started to look for alternatives and ways to fund reform initiatives. In 1999, they created the Defense Medical Oversight Committee (DMOC) to assist in the effort to identify the means by which the MHS could be improved [Ref. 2:p. 11]. This advisory panel, chaired by a service Vice Chief, consisted of all four service Vice Chiefs, service Under Secretaries, and the three Surgeons Generals. The JCS understood that MHS reforms would require billions in additional funds and empanelled the DMOC to recommend resourcing options for the DHP, and to "recommend ways to close healthcare benefit gaps that harm recruiting and retention and have angered thousands of older retirees" [Ref. 19:p. 2]. The DMOC then passed its recommended provisions up to the JCS [Refs. 22-25:p. 8].

The JCS urged the Secretary of Defense (SecDef), William Cohen, to back all the DMOC's recommended provisions, but at a minimum to back at least one substantial initiative covering all categories of beneficiaries. The proposals included ending TRICARE Prime co-pays, ending TRICARE Prime annual enrollment fees for retirees, extending TRICARE Prime Remote boundaries for active-duty dependents, expanding

the TRICARE Senior Prime demonstration project, adding a pharmacy benefit for Medicare-eligibles, creating a government sponsored Medigap insurance plan, creating a TRICARE Prime Remote program for retirees under 65, and fully funding the current and future DHP [Ref. 20:p. 2].

Of the proposals, only two were endorsed by Secretary Cohen and submitted for inclusion within the President's Budget. Secretary Cohen based his endorsement on what the DoD could possibly pay for if not given more money to fund reform [Ref. 26]. The two provisions were to end TRICARE Prime co-pays for active-duty dependents and to expand TRICARE Prime Remote boundaries for active-duty dependents [Ref. 20:p. 3]. The retiree initiatives were not considered a top priority by the DoD.

The Chairman of the JCS, Army General Henry H. Shelton, objected to this and continued to push the JCS proposals, no longer to the Secretary of Defense, but now to the individual lawmakers [Ref. 20:p. 3]. Perhaps the Secretary and others in DoD realized that the retiree lobbyist groups already had support for these measures in Congress. Knowing this, the SecDef may have wanted to push his immediate top priorities, on the assumption that Congress would add more benefits to include the retirees when it addressed these matters during the budget process.

In fact, Congress did address MHS reform. When Congress began to push reform through to the authorization and appropriation bills, the SecDef and JCS became concerned. They were getting the reform they wanted along with recognition for their efforts. However, they were getting the benefits without the additional funding to support

them [Ref. 27]. Some of the congressional proposals could cost as much as $116 billion over ten years [Ref. 28]. Secretary Cohen noted that these very expensive benefits would "threaten the ability to fund other critical defense priorities" [Ref. 27].

B. THE PRESIDENT'S PROPOSAL

FY00 represented a year when military pay and pensions received a big boost, while FY01 was expected to be the year the MHS was improved [Ref. 18:p. 2]. The President's FY01 budget gave special attention to military healthcare by citing several improvements. Although the President's Budget included both improvements endorsed by the SecDef, it failed to have the impact on healthcare that the FY00 budget had on pay and pensions [Ref. 18:p. 3].

The President's FY01 Budget included numerous improvements to the MHS. DHP funding was increased by $348 million to cover the rising cost of current programs. However, according to the General Accounting Office (GAO), the DHP would need $6 billion more over the next 5 years just to maintain current operations [Ref. 29]. The $348 million for FY01 was a needed addition, but according to Pentagon officials more would need to be added in future years to cover the $6 billion gap or to cover any added reform benefits [Ref. 26]. $50 million was added in the President's budget to eliminate co-pays for active-duty family members enrolled in TRICARE Prime and receiving civilian care, and $30 million was added to expand TRICARE Prime Remote to active-duty family members living far away from MTFs [Ref. 30 and Ref. 16:p. 3]. Also, budget initiatives

were recommended to "improve contracting practices to enhance access to care, ease enrollment, and provide a more uniform benefit," and to "optimize utilization of MTFs to bolster medical readiness and increase access to such facilities" [Ref. 30:p. 3]. Finally, the President's Budget indicates the DoD is studying a wide range of other improvements, including options to improve healthcare benefits for over-65 military retirees [Ref. 30:p. 3].

The President's Budget failed to address all of the problems affecting the MHS. Retiree benefits, benefit equity and cost equity were not seriously confronted. Pentagon Comptroller, William Lynn stated that the administration was "reviewing what they might do" for the over-65 retirees, but he was unsure of any pending actions [Ref. 18:p. 3]. His statement clearly suggests that he expected Congress to address this issue.

III. FY01 HEALTHCARE REFORM PROPOSALS

The political winds of public support, a budget surplus, and an election year made it possible for Congress to consider MHS reform bills [Ref. 31]. The President's budget contained only two significant MHS reform proposals, both of which specifically targeted active-duty families. Consequently, many bills were introduced in Congress addressing provisions of the MHS neglected by the President's budget. The problem Congress confronted was the funding of the reforms.

The question bracketing all MHS reform was, should the necessary funding be new money or should it be taken out of the DoD's current funding? The Secretary of Defense and JCS who had pushed for MHS reform were urging lawmakers to "proceed with caution" and avoid "mandating new unfunded benefits" [Ref. 32]. The DoD wanted increased healthcare benefits for its beneficiaries, but was very concerned about the high price tag attached to them. This issue was not seriously addressed until Congress took up its authorization and appropriation bills.

A. HOUSE PROPOSALS

The House initiated an important military healthcare reform bill even before the President's budget submission, dating back to September 28, 1999 of the 1st session of the 106th Congress. The bill, H.R. 2966 (titled "Keep Our Promise to America's Military

Retirees Act,") was introduced by Representatives Ronnie Shows, D-MS, and Charlie Norwood, R-GA [Ref. 33]. Their bill addressed two main issues.

First, retirees who entered the uniformed services prior to June 7, 1956 and their surviving spouses would be able to use TRICARE Standard or Extra, and would also be able to enroll in the FEHB program. These added benefits could be used in addition to the Medicare benefit. The DoD would pay the premiums for those electing to use the FEHB plan, relieving these beneficiaries of out-of-pocket costs [Ref. 33].

Second, uniformed services retirees and their dependents who entered after June 7, 1956 would be eligible for increased insurance coverage after they turn 65 [Ref.33]. They could either enroll in FEHB or continue to use TRICARE Standard or Extra, but could not choose both options [Ref. 34].

The cost to the federal government for this bill was $1.5 billion in discretionary spending over FY01-FY05 to cover additional TRICARE payments. The increase in direct spending for FEHB and Medicare costs was approximately $30 billion from FY01-FY05 and $74 billion from FY01-FY10 [Ref. 35].

Though this bill had 290 cosponsors, both Democratic and Republican, it was not passed prior to the start of the second session of the 106th Congress.

H.R. 2966 became H.R. 3573 in the 2nd session of the 106th Congress on February 2, 2000 under the same name and containing identical wording [Ref. 34]. The only real differences between these two bills were the dates of introduction and the Congressional Budget Office (CBO) cost estimates. H.R. 3573 would save $1.2 billion in discretionary

spending over 2001-2005 in TRICARE payments, and increase direct spending on FEHB and Medicare by about $36 billion over FY01-FY05, and $92 billion from FY01-FY10 [Ref. 36 and Ref. 37]. This proposed savings to discretionary spending is based on an estimated decrease in the use of TRICARE, offset by an increase in direct spending for FEHB and Medicare. This bill was the most expensive of the proposed reforms to MHS, with an estimated average annual cost of over $9 billion [Ref. 36].

H.R. 3573 had 305 supporters, more than the original bill. Various lobbyist groups, including the National Military Veterans Alliance (NMVA), The Military Coalition (TMC), and The Retired Officers Association (TROA), were in support of it [Ref. 38, Ref. 39, and Ref. 40]. According to military retiree organizations, the bill "offers the most comprehensive coverage for Medicare-eligible retirees [Ref. 41].

The next House bill addressing MHS reform was H.R. 3655, titled "Improved Medical Care for Troops and Retirees Act." This was introduced on February 15, 2000 by Representatives Neil Abercrombie, D-HI, and Ike Skelton, D-MO [Ref. 42]. The House Democrats proposed this bill as an alternative to H.R. 3573. H.R. 3655 contained numerous reform provisions costing about $150 million in FY01 and about $1.3 billion from FY01-FY05 [Ref. 43].

The first added benefit was making the Medicare subvention program permanent. The bill also increased the number of sites under the prior test demonstration project and provided that DoD would be reimbursed on a fee-for-service rate instead of the initial

adjusted HMO rate. The CBO estimated that this provision alone would cost $945 million over FY01-FY10 [Ref. 43].

Second, the FEHB demonstration program would be extended by one year for those already enrolled in the project, and would allow participants to keep coverage under FEHB after the project ends. Only those previously enrolled in the project would be included [Ref. 43].

The remaining provisions included a pharmacy benefit similar to the Pharmacy Pilot program for Medicare-eligible beneficiaries, expanding TRICARE Prime Remote boundaries, and elimination of TRICARE co-pays. This was identical to the President's budget request. Finally, a reduction in the catastrophic cap, a reimbursement for travel and the elimination of non-availability statements were proposed [Ref. 42 and Ref. 43]. H.R. 3655 had forty cosponsors and the support of the TMC lobby group [Ref. 41].

Representative Adam Smith, D-WA, introduced a final major House bill addressing MHS on March 16, 2000. The bill, H.R. 4030, titled "Enhancement of Military Benefits Act," was not entirely dedicated to healthcare, but the majority of its costs were [Ref. 44].

This bill had two main provisions. First, all retirees and their dependants would be allowed to enroll in FEHB. The DoD would pay the premiums of $15.7 billion over FY01-FY05 and $43 billion over FY01-FY10 [Ref. 45].

Secondly, Medicare subvention would increase its number of sites available, allow DoD to be reimbursed as a fee-for-service provider instead of the previously used

adjusted Health Maintenance Organization (HMO) rate, and it would become a permanent program [Ref. 45]. The CBO cost estimate for this provision was $945 million over FY01-FY10 [Ref. 45].

Lobby groups never fully supported H.R. 4030 because of the availability of similar bills containing more benefits. Although TROA supported this bill, they knew that it combined several costly initiatives and they felt it would be unlikely to win approval [Ref. 46].

Eight other military healthcare reform bills were introduced in the House during this period. They ranged from expanding the FEHB demonstration project to creating a permanent FEHB program, available to retirees worldwide. Most of these bills contained provisions that were similar to or contained in the previously mentioned bills [Ref. 47].

B. SENATE PROPOSALS

On the other side of Congress, the Senate was busy preparing and introducing bills of its own to reform the MHS. The first Senate bill, S. 2013, was sponsored by Senator John McCain, R-AZ., titled "Honoring Health Care Commitments to Servicemembers Past and Present Act of 2000" [Ref. 48]. Introduced on January 27, 2000, it preceded the House's new version of H.R. 2966 by only a few days.

McCain's bill would give healthcare delivery options to Medicare-eligible beneficiaries and their dependents. The first option was to make Medicare subvention permanent and available nationwide. A second option allowed Medicare-eligible retirees

to enroll in FEHB and made it available worldwide also. The FEHB option would be limited to 275,000 Medicare-eligible retirees only [Ref. 41:p. 982, and Ref. 49]. The third option expanded the mail-order and TRICARE retail pharmacy benefit nationwide to all Medicare-eligible beneficiaries [Ref. 49]. The proposed legislation limited the beneficiaries to choose only one of these healthcare delivery options.

S. 2013 also provided seven additional improvements for the MHS. First was the elimination of co-pays and deductibles for all active-duty families enrolled in TRICARE Prime. Second was to expand the boundaries of TRICARE Prime remote so active-duty families would be covered free-of-charge when they live far away from an MTF. A third and forth provision would promote efficiencies by consolidating and streamlining administrative processes and infrastructure. Fifth, an account to help fund the cost of these new benefits would be created, funded by savings generated from the previous efficiencies. A sixth provision would authorize the Secretary of Defense to enter into contracts with private industry to recover over-payments to civilian healthcare providers. Finally, the bill required the DoD to issue a nationwide TRICARE enrollment card to ease and facilitate the transfer of benefits for members who move from one TRICARE region to another [Ref. 49].

The CBO did not issue an estimate for S. 2013. It had unique provisions not included in other bills, including revenue generation, savings measures, and beneficiary options that are very difficult to capture due to individual preference or needs.

Though McCain's bill had only ten co-sponsors, it had the support of the TMC, including TROA and the NMVA [Ref. 41, Ref. 50, and Ref. 51].

The next Senate proposed bill was S. 2087, titled "Military Health Care Improvements Act of 2000." Introduced on February 23, 2000 by Senator John W. Warner, R-VA, S. 2087 was backed by both Republican and Democrat leaders and was "expected to be included in the fiscal 2001 defense authorization bill" [Ref. 52 and Ref. 41].

Senator Warner's bill would increase the number of test sites and extend their length to the end of FY05 for both Medicare subvention and the FEHB demonstration projects. The FEHB demonstration project would also be limited to 66,000 beneficiaries. A third demonstration project called the TRICARE Senior Supplement would also be extended to FY05. TRICARE Senior Supplement is a supplemental insurance program where enrollees pay a fee, lose eligibility for care in the MTFs, and TRICARE acts as a second payer to Medicare similar to an insurance provider [Ref. 52].

Another provision of S. 2087 included the nationwide expansion of the mail order pharmacy (but not its retail network) to Medicare-eligible beneficiaries. The enrollment fees for this pharmacy benefit would also be lowered. Another was the elimination of co-pays for TRICARE Prime beneficiaries. Others included the establishment of a patient safety tracking and reporting system, and expanding the TRICARE Prime remote boundaries. Finally, S. 2087 contained many other provisions that had little or no budgetary impact, such as studies or pharmaceutical identification [Ref. 53].

According to CBO estimates, S. 2087 would raise both direct spending to Medicare and discretionary spending to the DoD. Direct spending would increase by $457 million over FY01-FY05 and DoD spending would increase by $830 million over FY01-FY10 [Ref. 53].

Outside the Senate, support for the Warner bill was not as strong. Military organizations criticized it, stating "it would not make permanent either Medicare subvention or the federal employees health care program" [Ref. 54]. The NMVA used more direct language, saying " we are extremely disappointed" because those programs would not be made permanent [Ref. 39]. Further disappointing the retirees, S. 2087 provided for deductibles and enrollment fees to the pharmacy benefit and denied access to the retail pharmacy [Ref. 39]. The TMC also did not support S. 2087 because, in their view, it inadequately addressed coverage for retirees [Ref. 50].

Inside the Senate, S. 2087 has its naysayers also. Senator McCain stated that it "falls short of our pledge to reform the military health care delivery system for our veterans, especially our oldest veterans, retirees and their survivors" [Ref. 51]. Senator Warner acknowledged that S. 2087 "falls short of the expectations of the retired community," but he felt it was a "much needed first step" [Ref. 54].

On March 29, Senator Tim Johnson, D-S.D., introduced S. 2003, titled "Keep Our Promise To America's Military Retirees Act" [Ref. 55]. S. 2003 contained wording and costs identical to those in the House bill H.R. 3573. Consequently, there were two identical bills concurrently gaining support, one in the House and the other in the Senate.

Support for S. 2003 was high among Republicans, Democrats, and lobbyist groups [Ref. 55 and Ref. 56].

Influenced by competing bills and a lack of support from military retiree lobbyist groups, Senator Warner introduced yet another healthcare reform bill on May 1, 2000. Stressing that his first bill, S. 2087, was just to "solicit comment," his new bill would "build on his initial proposal" from February [Ref. 50 and Ref. 57].

Warner's newest bill, S. 2486, was titled the same as his previous bill the "Military Health Care Improvements Act of 2000" [Ref. 57]. This new legislation offered changes welcomed by the retiree organizations. According to Senator Warner, "after hearings and public forums held in Washington, DC and at military bases," we have "heard from military retirees and their veterans organizations." This was the premise for his new bill [Ref. 57].

S. 2486 addressed the main concerns of the TMC, including the NMVA and TROA, by adding two major provisions. First, the retail pharmacy benefit was added. Second, prescription drug benefit deductibles and enrollment fees were eliminated [Ref. 57 and Ref. 58]. CBO estimated the cost of these two additional provisions to be about $134 million for FY01 and about $580 million for FY01 –FY05 [Ref. 59 and Ref. 60].

The Senate introduced four other bills during this period. Again, most of the proposed provisions were included in the previously mentioned larger bills [Ref. 47].

THIS PAGE LEFT INTENTIONALLY BLANK

IV. FY01 HEALTHCARE REFORM BILLS

A. THE BUDGET RESOLUTION

The House and Senate approved a conference agreement for the concurrent budget resolution (CBR) (H. Con. Res. 290) on April 13, 2000 [Ref. 61]. Included in the resolution was an amendment by Senator Tim Johnson, D-SD. This established a reserve account setting aside money for improvements to military retirees' healthcare. The purpose behind Senator Johnson's amendment was to encourage action on military healthcare legislation. The proposed reserve account was unlimited in funding as long as it did not add to the federal deficit. This left the amounts to be funded in the reserve account up to the conferees [Ref. 62]. As noted in Chapter III, the reserve account had its desired effect.

The Senate Budget Committee Chairman, Senator Pete Domenici, R-NM, defeated the reserve account proposal in committee and then agreed to a compromise. The compromise specified that the reserve account would cover only the retiree health upgrades included by the Senate Armed Services Committee in the Senate passed FY01 Defense Authorization Act [Ref. 62].

During the conference on the budget resolution, the reserve account was reduced beyond Senator Domenici's recommendation, to a cap of $50 million in FY01, and a cumulative $400 million for FY01 through FY05 [Ref. 62].

TROA was "extremely disappointed that the budget resolution conferees failed to give the healthcare reserve account the priority it deserved." TROA stated the House and Senate would have to craft "alternate savings offsets to enact retiree healthcare relief" because the reserve account was too small [Ref. 62].

Based on the proposed initial estimates for military healthcare reform, the $50 million cap in FY01 for retiree healthcare upgrades fell short of its purpose. The reserve fund's purpose, other than to encourage legislative action, was to "fund improvements to healthcare programs for military retirees and their dependents in order to fulfill the promises made to them" [Ref. 63]. The budget resolution was not going to fulfill the MHS reform of a "lifetime health care commitment" that TROA and other military lobby groups wanted [Ref. 62].

According to other lawmakers, the $400 million reserve fund would help pay for the military retiree's prescription drugs [Ref. 64]. Retirees and their lobby groups agreed that "the pharmacy benefit is the most critical benefit," but argued that the $400 million would not go far enough to provide adequate healthcare for military retirees [Ref. 64].

Subsequently, the full House and Senate approved the military retiree reserve account at the conferees level in the FY01 CBR [Ref. 63].

B. DEPARTMENT OF DEFENSE APPROPRIATION ACT FOR FISCAL YEAR 2001

The appropriators acted next and had the "Department of Defense Appropriations Bill, 2001" completed before the National Defense Authorization bill.

The House bill, H. R. 4576 (FY01 Department of Defense Appropriation Bill) passed the House of Representatives on June 7, 2000. It included an increase in FY01 DHP funding of $542 million over the President's budget request. This was an increase of over $988 million from the FY00 DHP appropriation [Ref. 65].

Included in the additional $542 million was $280 million to support initiatives to improve TRICARE. The initiatives included $134 million to optimize use of the MTFs and improve TRICARE business practices, and to provide additional support staff to primary care providers in the military direct care system. $94 million was added to fund a TRICARE Senior Pharmacy program and $32 million was added to reduce the catastrophic cap for retired TRICARE beneficiaries. Finally, about $21 million was added to improve claims processing, fund a study on health care options for Medicare-eligible military retirees, and to reimburse travel payments for certain patients who have to travel long distances from their primary health care facility [Ref. 65].

Also included in the $542 million was $262 million for research and development programs. The two main programs were $175 million for breast cancer research and $75 million for prostate cancer research [Ref. 65].

Shortly after, the Senate passed its version of the bill, S. 2593 (Department of Defense Appropriation Bill, 2001) on June 13, 2000. The Senate bill consisted of an increase in FY01 DHP funding of $529 million over the President's budget request. This was an increase of over $976 million from the FY00 DHP appropriation [Ref. 59].

Included in the additional $529 million was $192 million for numerous small projects and proposals, and $137 million for a military retiree pharmacy benefit [Ref.59].

Also included in the $529 million was $337 million for research and development programs. The two main projects were the same as the House's, i.e., $175 million for breast cancer research and $100 million for prostate cancer research [Ref. 59]. (Table 1 gives a summary of the main provisions and their estimated cost).

Table 1,				
	Budget	House	Senate	conference/law
Total DHP (in millions of dollars).	11,600	12,143	12,130	12,117
Major adjustments to DHP (in thousands of dollars).				
Operations and Maintenance				
Medicare-eligible Health Options study				
		2,000		2,000
Claims Processing Initiative				
		3,600		3,600
MTF Optimization				
		134,000		
Reimbursement for Travel Expense				
		15,000		
Reduced Catastrophic Cap				
		32,000		
Senior Pharmacy Benefit				
		94,000		
Military Retiree Pharmacy Benefit				
			137,000	
Senior Pharmacy Increase				
				100,000
Research and Development				
Breast Cancer Research Program				
		175,000	175,000	175,000
Prostate Cancer Research Program				
		75,000	100,000	100,000
Medical Research Program				
			50,000	50,000

Table 1. Appropriation bills comparison [After Ref. 66]

A conference agreement on defense appropriations (H. R. 4576) was approved in the House on July 19, and in the Senate on July 27. The conference agreement provided for an increase to the DHP of $963 million over the FY00 appropriation level. Included in the $963 million was the elimination of TRICARE Prime co-pays and the expansion of TRICARE Prime Remote for active-duty families. According to appropriators, the FY01 appropriation also contained enough money to "implement expanded pharmacy access to retirees" [Ref. 61].

Based on a Secretary of Defense and Office of Management and Budget (OMB) estimate, the pharmacy benefit would cost about $200 million for FY01 [Ref. 66]. The conferees recommended addressing this by "providing an additional $100 million" for a senior pharmacy benefit in the DHP appropriation. They also included in the conference agreement $100 million in "contingent emergency appropriations." This money would be available if the President and Congress thought it necessary to further fund the pharmacy initiative [Ref. 66].

The conferees fully funded both the breast cancer and the prostate cancer research programs, as were a Medicare-eligible Health Options study and initiatives to improve claims processing. Reimbursement for travel expenses and money to reduce the catastrophic cap were not approved for funding [Ref. 66].

A comparison of the President's budget, the House and Senate appropriation bills, and the appropriations conference agreement is provided in Table 1.

The approved conference agreement was then sent to the President to be signed into law. The President signed the enrolled bill (H. R. 4576), the "Department of Defense Appropriations Act, 2001" into law (P. L. 106-259) on August 9, 2000 [Ref. 67].

C. NATIONAL DEFENSE AUTHORIZATION ACT FOR FISCAL YEAR 2001

The House approved H. R. 4205, the "Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001" on May 18, 2000 [Ref. 61]. The House argued that the President's budget request neglected any initiatives to improve military health care benefits for Medicare-eligible military retirees, but were encouraged by the JCS to add major reforms themselves [Ref. 68].

A major concern to the House was what they determined to be an incomplete reform effort by the DoD. In an effort to determine what reforms were required, the House Armed Services Committee conducted oversight hearings, informal investigations, and meetings with all stakeholders involved. This significant endeavor produced findings that formed the basis for the House authorization bill [Ref. 68].

The findings included the fact that the "prescription drug benefit to Medicare-eligible military retirees and their dependents was given the highest priority by all stake holders" [Ref. 68]. A second finding was that all the demonstration programs currently running for retired military Medicare-eligible beneficiaries were not sufficiently developed to become permanent [Ref. 68]. Thirdly, Medicare's cost to process claims was found to be three to four times cheaper than for the MHS to process. This cost

proved to the Committee that a savings of hundreds of millions of dollars annually could be retained by investing in reform of the MHS claims systems [Ref. 68]. A fourth finding concerned problems with access to the MTFs due to poor information technology usage and funding limits that both reduced MHS optimization. Finally, MHS benefits were found not to be easily portable from one region to the next [Ref. 68].

Based on these findings, the Committee recommended 39 changes in the authorization bill. These changes, totaling $257 million in FY01 and $2.94 billion in FY01 through FY05 in discretionary spending, and $21 million in FY01 and $165 million for FY01 through FY05 in direct spending, were not inexpensive recommendations [Ref. 69]. (Appendix A contains a complete list of MHS authorization provisions by both the House and Senate).

The largest reform recommendation by the House in the authorization bill was the implementation of the TRICARE Senior Pharmacy program. At a cost of $94 million in FY01 and over $2 billion from FY01 through FY05, it was by far the single most expensive new provision for the DHP in the bill. This benefit allows Medicare-eligible beneficiaries to use MTF pharmacies free of charge, the DoD's National Mail Order Pharmacy (NMOP), the retail pharmacy network, and non-network providers. These beneficiaries would have the same co-pays as other beneficiaries, with no enrollment fee required [Ref. 70].

The Committee recommended the extension of the TRICARE Senior Supplement program, the TRICARE Senior Prime demonstration program, and the FEHB

demonstration program to the end of FY03. These extensions would "ensure each program receives a fair and comprehensive test," to "make recommendations to Congress on what a permanent program of healthcare for the Medicare-eligibles should provide" [Ref. 68 and Ref. 70].

Other programs authorized included the elimination of co-pays and the expansion of TRICARE Prime Remote for active-duty families. Recommendations to increase DHP funds for the modernization and optimization of MTFs, to provide additional support staff for providers, and to improve claims processing were approved by the Committee. Finally, increases to the FY01 DHP were recommended for reimbursement for certain travel expenses, to reduce the catastrophic cap, for a pharmaceutical identification program, and for a patient safety tracking system [Ref. 68].

The Senate Armed Services Committee used H. R. 4205 as a platform for their version of the S. 2549, "National Defense Authorization Act for Fiscal Year 2001" [Ref. 61]. The Committee stated that this year it "focused on improving military health care for our active duty and retired personnel and their families" [Ref. 60]. The Committee viewed its approximately 35 recommended changes and additions in the authorization bill to be a first step toward providing a comprehensive healthcare benefit to the MHS and retired military Medicare-eligible beneficiaries [Ref. 60].

Once again the largest reform recommendation in the authorization bill concerned the pharmacy benefit. The Senate committee also wanted to expand the pharmacy program to include Medicare-eligible beneficiaries. This benefit was the same as the

House version except it would not cover the use of non-network providers. The cost of this program was $49 million in FY01 and $623 million for FY01 through FY05 [Ref. 60 and Ref. 70].

The Committee also recommended the extension of the TRICARE Senior Supplement program, the TRICARE Senior Prime demonstration program, and the FEHB demonstration program through December, 2005 [Ref. 60].

Numerous other programs were authorized that were identical to the House's recommendation. These included the elimination of co-pays and the expansion of TRICARE Prime Remote for active-duty families. A recommendation was included to increase DHP funds for the modernization and optimization of MTFs, and to provide additional support staff for providers. Finally, increases to the DHP were recommended for a pharmaceutical identification program, and for a patient safety tracking system [Ref. 60].

Senator John McCain brought attention to what he stated was of great concern to the military retirees and their families, i.e., the "broken promise" of a lifetime of free medical care, "especially for those over-age 65" [Ref. 60]. He noted that "while the committee included some key health care provisions, they failed to meet what I think is the most important requirement," the permanent "restoration of this broken promise" [Ref. 60]. (See Appendix A for a complete list and comparison of the House and Senate authorization bills).

On June 7th, the Senate Armed Services Committee added an amendment by Senator John Warner to S. 2549. Senator Warner wanted a fully funded, permanent program that would provide Medicare-eligible retirees and their family members a choice of using TRICARE Prime, or the option of using TRICARE Standard as a second payer to Medicare. These benefits would have either no premiums or enrollment fees, or would have the same premiums and enrollment fees as for the under-65 retirees. He also sought to open up the DoD retail and NMOP programs to Medicare-eligibles [Ref. 71].

Secretary Cohen again stated that the "administration supports further improvements in military health care." He also admitted that they were "concerned that more work was needed on these proposals before deciding which, if any, should be pursued and how to fund those without hurting our overall health care operations or other defense priorities" [Ref. 72].

Senator Warner's amendment was financially limited by Senate rules pertaining to the budget resolution's cap on the amount of funding available for retiree health care improvements. His amendment needed to stay within the Senate's previously approved budget cap. To accomplish this and satisfy his program goals, the Senator had to limit his program to begin in October, 2001 and end in October, 2003. But he continued to stress his "continuing priority to ensure permanent authority and funding in 2001" [Ref. 71].

Senator Warner's amendment replaced three of the original provisions in the proposed Senate bill. These included the extensions to FY05 of the FEHB

demonstration, the TRICARE Senior Supplemental demonstration, and the TRICARE Senior Prime demonstration programs [Ref. 73].

TROA supported this amendment as a step in the right direction. They were looking for the conference committee to support a "change in position by the House leadership" and to "spark Senate leaders to find a way around the budget limits imposed" [Ref. 71].

On July 13, 2000, the Senate passed S. 2549 with Senator Warner's amendment. Next both authorization bills, S. 2549 and H. R. 4205, went to conference.

The late July conference agreement on the defense appropriation bill ensured that the caps imposed by the Senate for retiree health care upgrades would be adhered to. If Congress were to fully fund Senator Warner's amendment and make it permanent, they would have to find a way around the caps.

Secretary Cohen stated that while "our military people will benefit substantially from both bills' improvements" to the DHP, "the bill needs to include full funding for this new benefit, about $200 million for FY01" [Ref. 72]. Secretary Cohen was again concerned that an unfunded MHS program would be imposed on the DoD, thus negatively affecting high priority DoD readiness programs.

On September 21, Representative Steve Buyer, R-IN, proposed making the Warner proposal permanent. To ensure it would not have to compete with other defense programs, he also proposed setting up a trust fund to pay for it [Ref. 71]. Representative Buyer indicated that "House leaders will agree to support funding these proposals this

year" [Ref. 71]. Senator Warner indicated that he was "optimistic" that Congress will "enact a defense authorization bill that for the first time will, over Pentagon objections, give veterans military health care coverage for life" [Ref. 74]. The Warner amendment had now picked up the name TRICARE-For-Life by military lobby groups and news organizations. TRICARE-For-Life eventually became the name of the retiree benefit passed by the conference agreement.

A major decision was made during conference to classify the retired military benefits as an entitlement. "New and existing medical benefits to beneficiaries age 65 and older provided by the DoD would become an entitlement" [Ref. 75]. If TRICARE-For-Life passed as an entitlement, not only would the cap on the reserve fund for military retiree healthcare be exceeded, but the budget resolution cap for entitlement spending would also be exceeded. The Senate and House discussed ways to bypass the budget resolution caps.

In conference, the new entitlements were agreed to along with numerous other MHS provisions. The House approved H. R. 4205, titled the "Enactment of Provisions of H. R. 5408, The Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001" on October 11, 2000 [Ref. 76]. The following day, Senator Warner offered a motion on the Senate floor to have the budget caps waived. The motion was approved, freeing the Senate to pass the authorization conference agreement containing all the MHS reform proposed [Ref.77]. The Senate approved the bill and forwarded it to the President for his signature.

The approved conference agreement, H. R. 4205, was signed by President Clinton on October 30, 2000 as P. L. 106-398 [Ref. 71]. It contained two main benefits for Medicare-eligible retirees. These were to be funded as entitlements using an accrual trust fund similar to what Representative Buyer had proposed. The fund would be called the "DoD Medicare-Eligible Retiree Health Care Fund" [Ref. 70]. The new TRICARE-For-Life provision (slightly expanded from the Warner amendment) and the implementation of a TRICARE Senior Pharmacy program would now be entitlements.

As previously mentioned, the final authorization act contained the TRICARE-For-Life provision. This permanent provision became effective October 2001. The TRICARE Senior Prime demonstration project would remain in effect until October 2001 to fill in the gap until TRICARE-For-Life began. This cost about $1.9 billion for FY01 through FY03. CBO estimated that these new benefits would increase direct spending beginning in FY01 by $23 million and from FY01 through FY10 by about $60 billion. This included the cost of the TRICARE Senior Prime demonstration project, the expected increase in MHS users, the TRICARE-For-Life benefit, and the increase in the quality of the benefit provided (more expensive and better procedures that may not have been accomplished had they been paid for out-of-pocket) [Ref. 76].

A second provision is the implementation of the TRICARE Senior Pharmacy program. This permanent provision becomes effective April 2001. The pharmacy program provides retired military Medicare-eligible beneficiaries and their families the same pharmacy benefit available to other MHS beneficiaries with no enrollment fees.

They are allowed to use MTFs, NMOP, the TRICARE retail network, and non-network pharmacies [Ref.70 and Ref. 78]. This benefit was expected to cost $94 million in FY01 and $2 billion for FY01 through FY05 [Ref. 70].

The DoD is required to pay $29 billion into the trust fund from FY03 through FY10. The DoD plans to save approximately $21.4 billion over the same period due to not paying for that care out of its discretionary funds. Congress intends to appropriate the $1.9 billion for the TRICARE Senior Prime demonstration project, pull the $21.4 billion back from future DoD appropriations, and appropriate the anticipated $29 billion for the DoD to make its accrual payments. Because benefits would be paid before the accrual payments are made ($60 billion over 10 years compared to only $29 billion to be recorded) the U. S. Treasury would make annual payments to cover the unfunded liability [Ref. 76 and Ref. 79].

There were approximately forty additional provisions contained in the authorization act. The original two provisions from Secretary Cohen to eliminate co-payments and to expand the TRICARE Prime Remote for active-duty and their families were approved [Ref. 78]. The initiatives to optimize use of the MTFs, to provide additional support staff for providers, to improve claims processing, and for a patient safety tracking system were included. Also approved was the pharmaceutical identification program, the reimbursement for certain travel expenses, and the reduction of the catastrophic cap [Ref. 78 and Ref. 70]. (Appendix A is provided as a complete reference for all provisions included in the final authorization conference agreement).

The groundwork has been laid with the passage of the authorization and appropriation acts. It is up to the DoD to act upon and make the new reform initiatives work.

Congress approved provisions for optimization, modernization, improved claims processing, and additional support staff. All these were to reform the MHS and remedy ongoing problems. They will not impact DoD payments to the trust fund after FY10 or the increased usage of the MHS by the over-65 population.

The retired military Medicare-eligible beneficiaries will be more likely to use the MHS because of lower cost and a perceived better benefit. They may also seek care that they previously would not have due to the high cost they once paid out-of-pocket (medications included).

The DoD will need to provide more care to the retired population via the MHS that was not considered part of their primary mission. The MHS may not be prepared for the future influx of retirees and the unique care they will require. The approved increase in support staff will need to focus on the new Medicare-eligible beneficiaries, not necessarily helping ease the active-duty family problems of access to care. These concerns need to be addressed by the DoD and future legislative actions.

THIS PAGE INTENTIONALLY LEFT BLANK

V. SUMMARY AND CONCLUSIONS

A. SUMMARY AND CONCLUSIONS

Congress addressed MHS reform for FY01 by passing legislation to create additional benefits for military retired Medicare-eligible beneficiaries, by increasing funding for the DHP, and numerous other initiatives covering all MHS beneficiaries.

> "This is a huge win for military retirees," said U.S. Representative Floyd D. Spence, Chairman of the House Armed Services Committee, "Healthcare for service members and their families is a major component of the military benefits package. The Administration had promised to include significant healthcare improvements for service members and military retirees in their budget proposal, but failed to deliver. I am extremely proud to say that the House-Senate conference committee accepted the challenge and provided permanent lifetime healthcare to America's military retirees and their eligible family members" [Ref. 80].

This legislation was not supported by all of Congress. Senator Robert Kerrey, D-NE, was just one Senator who voted against the authorization conference agreement. Senator Kerrey voted against it, prefacing his vote by asking, "what problem are we attempting to solve at an eventual annual cost of $10 billion" [Ref. 84]? He stated that "By changing the law, we will in essence be providing a subsidy for military retiree health insurance coverage that contains no deductibles or co-payments and a generous prescription drug benefit. Imagine the cost if we did the same for all Medicare beneficiaries" [Ref. 84]?

Senator Kerrey gave four reasons for voting against the authorization bill that included the TRICARE-For-Life provision. First, he stated that supporting this measure "exaggerates the promise that was made to the men and women who volunteered and

served in our Armed Forces" [Ref. 84]. In his view, military retirees were well served by Medicare, noting that "Medicare is healthcare" [Ref. 85].

Secondly, he argued that acceptance of this provision is an admission that "Medicare is an inadequate program" [Ref. 84].

His third objection was that the "source of the money will, of course, be individual and corporate income taxes" [Ref. 84]. He likens this to a tax payer subsidy of military retirees' benefits.

Finally, he explained that we are in danger of breaking the budget caps on a habitual basis [Ref. 84]. "The defense conference agreement requires $60 billion worth of spending beyond the budget resolution." He notes that others are saying to him, "don't worry, we have to get out of town" [Ref. 86]. Senator Kerrey implied that others are agreeing without caring about the future impact of the healthcare spending provisions, but they just want to finish the session.

Senator Phil Gramm, R-TX, also voted against the bill, arguing that,

> "The House entered into that conference with a program that cost $945 million. The Senate went into conference with a program that cost $466 million. They came out of conference with a program that cost $60 billion, and committed us to a 70-year debt of $200 billion" [Ref. 86].

He believed "we are all thinking that there is no end to American prosperity and American surpluses""[Ref. 86].

Senators supporting the legislation outnumbered the opposition, 84 to 9. Supporters claimed that these Medicare-eligible military retirees were "time and time again, told they would have for life their healthcare" [Ref. 85].

Senator Warner countered the arguments of Senator Kerrey and Senator Gramm with claims that we do "have an obligation to military retirees," and that we "have to find a way to fix the healthcare system for retirees" [Ref. 85].

The initiatives approved for the MHS to improve problems with claims processing, increased access to MTFs, standardized benefits, and optimized use of MTFs help all beneficiaries. Two initiatives imposed on the DoD -- the reduction in the catastrophic cap and reimbursement for certain travel expenses -- were both included in the authorization bill although funding for them was not included in the appropriation bill. Thus Secretary Cohen was correct in warning Congress against adding new benefits without funding.

This mismatch between the authorization and appropriation bills will need to be addressed by a joint effort between DoD, the authorizers, and the appropriators. They can resolve this problem any number of ways. The two provisions in question did not have specific start dates, so they may agree to hold off until FY02 to start and fund them. They may decide to pass a supplemental bill to fund them in FY01. They may reprogram money or require the DoD to reprogram money from other programs to fund them. Finally, they may decide that DoD will need to pay for them out of its current appropriation. The DoD must conform to the law and implement the programs when tasked to do so [Ref. 83].

General Shelton observed that, "keeping our promise of ensuring quality healthcare for military retirees is not only the right thing to do, it also is a pragmatic

decision because it sends a strong signal to those considering a career in uniform" [Ref. 81]. Even with the funding issue on the two authorized provisions, the General saw this as a victory for the military compensation package [Ref. 81].

Military retiree lobby groups also claimed a victory after passage of the authorization and appropriations bills. They had gained both health coverage for life and a generous pharmacy benefit for military retirees. TROA boosted that this was an "extraordinary grassroots victory" for military retirees and for TROA [Ref. 82].

Some were not as encouraged as the retired military lobby groups. Henry Aaron, a senior fellow at the Brookings Institution said, "It's interesting that Congress recognizes that for this one group the Medicare benefit package isn't adequate. One might well ask that if it isn't good enough for men and women who served in the armed forces, why is it good enough for men and women who spent a lifetime paying federal payroll taxes" [Ref. 81]? Others, like Steven Kosiaic, Director of Budget Studies for the Center for Strategic and Budgetary Assessments, observed that "This is a pretty expensive proposition. It's not likely to improve recruitment or convince people to stay in the military. The more effective way is to target pay increases that would have an immediate impact on people's families" [Ref. 81].

Supporters of the legislation, like Representative John M. Spratt Jr., D-SC, countered these arguments. His view was that "the retired veterans are an exception who deserve more than Medicare because they were promised lifetime health care when they enlisted in the military years ago" [Ref. 81].

Still others, like Representative David R. Obey, D-WI, voted for the MHS reform because, "I believe in health care from the cradle to the grave and voting to help this group may mean a higher level of shame for not covering every group" [Ref. 81]. Representative Obey said he would vote for any improvement in health care. Still others saw this vote as a chance to promote expanded federal healthcare or a nationwide program.

Both Republicans and Democrats had qualms about adding a permanent new entitlement. As one analyst noted, "Looked at from a federal budget perspective, it's troubling to make a significant new entitlement like this. But looked at from the perspective of equity, retired civilian bureaucrats already have similar coverage as this new plan," said Robert Reischauer, president of the Urban Institute. [Ref. 81].

Congress addressed the problems of the MHS by passing authorization and appropriation bills containing over forty reform provisions. By adding more healthcare benefits and not aligning them with the primary mission of the MHS, Congress failed to act on the problem of the MHS size. Also, none of the MHS reforms passed conform to the primary mission of keeping active forces well during conflict.

Senator Gramm argued that we are making a mistake by "committing to $60 billion worth of new programs" that have "never been tested, and committing to a $200 billion liability over the next 70 years" [Ref. 86]. The US military has been called a "social testing ground," used to determine whether new policies can be implemented on a grand scale, and accelerate public acceptance. TRICARE-For-Life may have been our

leaders righting what they perceived as an institutional wrong done to military retirees a long time ago. But with the baby boomer population expected to begin retiring in 8 to 10 years, and the nation's Medicare program losing money, the nation will need a strong surplus to keep healthcare viable [Ref. 87].

B. MILITARY HEALTHCARE REFORM CHAPTER SUMMARY

This thesis explored and documented the changes to the military healthcare benefit enacted in 2000, and identified and explained the reasons behind them. Specific objectives of this analysis were to:

- Determine the principle factors that shaped congressional approval of MHS reform initiatives.
- Describe suggested reform initiatives.
- Identify and document legislative actions reforming the MHS.

Chapter I provided the research questions and a chronological background of past and current MHS policy. Current demographics were detailed to provide the reader with an idea as to the scope of the MHS. Finally, problems were described which necessitated reform of the MHS.

Chapter II described recent demonstration projects, DoD and JCS proposals for MHS reform and the portions of the President's budget concerning the DHP.

Chapter III presented reform initiatives proposed by the House and Senate along with proposals and recommendations from various lobbyist groups. The proposals were

described in detail, including their sponsors, the costs entailed, justifications, and issues that were left unresolved.

Chapter IV detailed the MHS reform that was enacted for FY01. This discussion included a reserve fund in the CBR established to encourage action on retired military healthcare reform. This was followed by analysis of the House and Senate versions of the appropriations bill and the conference bill submitted to the President for approval. The House and Senate versions of the authorization bills were described next, including an important amendment by Senator John Warner. During conference on the final authorization bill, changes were made to the budget resolution. Significant changes were also made to the authorization bill. This concluded with the President signing the agreed upon conference bill.

Chapter V reviewed the FY01 legislative reform, recommendations made during the budget process, and contrasting views of the approved bill, closing with debate over the approved reform. Finally, this chapter proposes recommendations for future research.

C. RECOMMENDATIONS FOR FUTURE RESEARCH

Future research considerations should be given to the overall size of the MHS. One of the problems with the MHS was its size. What is the implication of the MHS's continued downsizing in comparison to its expanding product, the health benefit?

A second consideration would be to look into future medical readiness programs. The MHS down-sized its hospitals at a rate of 5.4 percent in FY99 and 7.9 percent in

FY00, cut procurement 20 percent in FY99 and 10 percent in FY00, and reduced other non-Operations and Maintenance procurement 19.2 percent in FY99 and 37.6 percent in FY00 [Ref. 16]. Meanwhile the 1997 QDR emphasized the importance of savings at the expense of infrastructure [Ref. 14]. What effect will this continued downsizing trend have on peacetime and wartime healthcare, and how will this be prevented from negatively affecting medical readiness?

A third area of research concerns how the reform and increases in the FY01 authorization and appropriation acts for retired military Medicare-eligible beneficiaries will affect future DoD funding, procurement, and readiness issues.

APPENDIX. FY 2001 Defense Authorization Act

Senate Mark (S. 2549)	House Mark (H.R 4205)	Final Bill – H.R. 5408
Defense Health Programs. FY 2001 Authorization for Defense Health Programs: $11,401,723,000 for O&M; $ 290,006,000 for procurement	**Defense Health Programs.** FY 2001 Authorization for Defense Health Programs: $11,571,523,000 for O&M; $ 290,006,000 for procurement.	**Sec. 106. Defense Health Programs.** FY 2001 Authorization for Defense Health Programs: $ $11,480,123,000 for O&M; $ 290,006,000 for procurement.
Sect. 611. Extension of Certain Bonuses and Special Pay Authorities for Reserve Forces. Extends authority to pay special pay for critically short wartime health specialists in Selected Reserves to December 1, 2001 and the repayment of loans for certain health professionals until December 1, 2001.	**Sect. 611. One -Year Extension of Certain Bonuses and Special Pay Authorities for Reserve Forces.** Extends authority to pay special pay for critically short wartime health specialists in Selected Reserves to December 31, 2001 and the repayment of loans for certain health professionals until January 1, 2002.	**Sect. 621. Extension of Certain Bonuses and Special Pay Authorities for Reserve Forces.** Extends authority to pay special pay for critically short wartime health specialists in Selected Reserves to December 31, 2001 and the repayment of loans for certain health professionals until January 1, 2002.
Sect. 612. One-Year Extension of Certain Bonuses and Special Pay Authorities for Nurse Officer Candidates, Registered Nurses and Nurse Anesthetists. Extends this authority until Dec. 1, 2001	**Sec. 612. One-Year Extension of Certain Bonuses and Special Pay Authorities for Nurse Officer Candidates, Registered Nurses and Nurse Anesthetists.** Extends this authority until Dec. 31, 2001	**Sec. 622. Extension of Certain Bonuses and Special Pay Authorities for Nurse Officer Candidates, Registered Nurses and Nurse Anesthetists.** Extends this authority until Dec. 31, 2001
Sect. 614. Consistency of Authorities for Special Pay for Reserve Medical and Dental Officers. Makes the amount of special pay for reserve medical and dental officers consistent.	**Sect. 614. Consistency of Authorities for Special Pay for Reserve Medical and Dental Officers.** Makes the amount of special pay for reserve medical and dental officers consistent.	**Sect. 625. Consistency of Authorities for Special Pay for Reserve Medical and Dental Officers.** Makes the amount of special pay for reserve medical and dental officers consistent.
Sect. 615. Special Pay for Physician Assistants of the Coast Guard. Authorizes the payment of a special pay to Coast Guard physician assistants on the same basis as non-physician health care providers in the military services	**Sect. 615. Special Pay for Physician Assistants of the Coast Guard.** Authorizes the payment of special pay to Coast Guard physician assistants on the same basis as non-physician health care providers in the military services.	**Sect. 627. Special Pay for Physician Assistants of the Coast Guard.** Authorizes the payment of special pay to Coast Guard physician assistants on the same basis as non-physician health care providers in the military services.
Sect. 616. Authorization of Special Pay and Accession Bonus for Pharmacy Officers. Authorizes special pay and accession bonuses for pharmacy officers.		**Sect. 628. Authorization of Special Pay and Accession Bonus for Pharmacy Officers.** Authorizes special pay and accession bonuses for pharmacy officers.

Sect. 617. Corrections of references to Air Force veterinarians. Clarifies that special pay for board certified veterinarians in the armed forces and the Public Health Service includes Air Force biomedical science officers who hold degrees in veterinary medicine.		**Sect. 629. Corrections of references to Air Force veterinarians.** Clarifies that special pay for board certified veterinarians in the armed forces and the Public Health Service includes Air Force biomedical science officers who hold degrees in veterinary medicine.
Sect. 618. Entitlement of Active Duty Officers of the Public Health Service Corps to Special Pays and Bonuses of Health Professionals of the Armed Forces. Makes special pays and bonuses for active duty officers of the Public Health Service Corps equal to those to health professional officers of the Armed Forces.		**Sect. 634. Entitlement of Active Duty Officers of the Public Health Service Corps to Special Pays and Bonuses of Health Professionals of the Armed Forces.** Makes special pays and bonuses for active duty officers of the Public Health Service Corps equal to those to health professional officers of the Armed Forces.
Title VII – Health Care	**Title VII--Health Care Provisions**	**Title VII--Health Care Provisions**
Subtitle A--Health Care Services	**Subtitle A--Health Care Services**	**Subtitle A--Health Care Services**
Sec. 732. Provision of Domiciliary and Custodial Care for CHAMPUS Beneficiaries. Caps DoD domiciliary and custodial care program costs at $100 million per year. Requires DoD to move quickly to implement a case management program. Grandfathers those who participated in DoD's home health care demonstration program and allows their continued participation in the case management program without regard to age.	**Sec. 703. Provision of Domiciliary and Custodial Care for CHAMPUS Beneficiaries and Certain Former CHAMPUS Beneficiaries.** Caps DoD domiciliary and custodial care program costs at $100 million per year. Authorizes SecDef to reimburse certain former CHAMPUS beneficiaries for costs incurred during a period of temporary ineligibility for such services under CHAMPUS.	**Sec. 701. Provision of Domiciliary and Custodial Care for CHAMPUS Beneficiaries and Certain Former CHAMPUS Beneficiaries.** Caps DoD domiciliary and custodial care program costs at $100 million per year. Requires DoD to move quickly to implement a case management program. Grandfathers those who participated in DoD's home health care demonstration program and allows their continued participation in the case management program without regard to age. Authorizes SecDef to reimburse certain former CHAMPUS beneficiaries for costs incurred during a period of temporary ineligibility for such services under CHAMPUS. Directs Comptroller General to report on the effectiveness of the existing coordination of the basic TRICARE program with the program for persons with disabilities and the individual case management program as they

		relate to meeting the health care needs of disabled dependents of active duty family members.
Sec. 737. Transition of Chiropractic Health Care Demonstration Program to Permanent Status. Would make permanent the provision of chiropractic health care services to enrollees in TRICARE Prime. Directs SecDef to develop and implement a plan to make available chiropractic services that requires a referral by a primary care physician. Provision would continue services at existing demonstration sites until 180 days after the date of enactment of this Act, at which time Prime enrollees would continue to have available chiropractic services.	**Sec. 737. Chiropractic Health Care for Members on Active Duty.** Requires SecDef to submit a plan to phase in over five years permanent chiropractic health care services for all active duty personnel. Requires SecDef to continue to provide the same level of chiropractic services during FY 2001 as were provided during FY 2000 to include as a minimum, care for neuro-musculoskeletal conditions typical among military personnel on active duty.	**Sec. 702. Chiropractic Health Care for Members on Active Duty.** Requires SecDef to submit a plan by March 31, 2001 to phase in over five years permanent chiropractic health care services for all active duty personnel. Requires SecDef to continue to provide the same level of chiropractic services during FY 2001 as were provided during FY 2000 to include as a minimum, care for neuro-musculoskeletal conditions typical among military personnel on active duty.
Sec. 734. School-required Physical Examinations for Certain Minor Dependents. Directs SecDef to provide eligible dependents between the ages of 5 and 12 years of age a physical examination when such an examination is required before the child can enroll in a school. No copayment would be required for Prime enrollees. Those who are in TRICARE Standard or Extra would have the same co-payments as for other similar health care visits.		**Sec. 703. School-required Physical Examinations for Certain Minor Dependents.** Directs SecDef to provide eligible dependents between the ages of 5 and 12 years of age a physical examination when such an examination is required before the child can enroll in a school. No copayment would be required for Prime enrollees. Those who are in TRICARE Standard or Extra would have the same co-payments as for other similar health care visits.
Sec. 735. Two-Year Extension of Dental and Medical Benefits for Surviving Dependents of Certain Deceased Members. Extends medical and dental benefits for surviving dependents of certain deceased members from one year to three years.		**Sec. 704. Two-Year Extension of Dental and Medical Benefits for Surviving Dependents of Certain Deceased Members.** Extends medical and dental benefits for surviving dependents of certain deceased members from one year to three years.
Sec. 736. Extension of Authority for Contracts for Medical Services at Locations Outside Medical Treatment Facilities. Extends from December 31, 2000 to September 30, 2002, the authority to enter personal services contracts with physicians for medical screening of enlistment applicants. This will allow SecDef to complete the evaluation of alternative medical screening strategies and sustain the pace of medical screening for armed forces applicants by	**Sec 701. Extension of Authority for Contract Physicians at Military Entrance Processing Stations and Elsewhere Outside Medical Treatment Facilities.** Extends from December 31, 2000 December 31, 2002, the authority to contract with physicians for medical screening of enlistment applicants at military entrance processing stations and other locations. This will allow SecDef to complete the evaluation of alternative medical screening strategies and sustain the pace of medical screening for	**Sec 705. Extension of Authority for Contract Physicians at Military Entrance Processing Stations and Elsewhere Outside Medical Treatment Facilities.** Extends from December 31, 2000 December 31, 2002, the authority to contract with physicians for medical screening of enlistment applicants at military entrance processing stations and other locations. This will allow

extending contracting authority for an additional period of time.	armed forces applicants by extending contracting authority for an additional period of time.	SecDef to complete the evaluation of alternative medical screening strategies and sustain the pace of medical screening for armed forces applicants by extending contracting authority for an additional period of time.
Sec. 733. Medical and Dental Care for Medal of Honor Recipients and their Dependents. Extends lifetime medical and dental care provided through DoD to medal of honor recipients and their dependents.	**Sec. 702. Medical and Dental Care for Medal of Honor Recipients.** Authorizes medal of honor recipients and their dependents not otherwise entitled to military medical and dental care to be provided such care in the same manner as care is provided to those entitled to retired pay.	**Sec. 706. Medical and Dental Care for Medal of Honor Recipients and their Dependents.** Extends lifetime medical and dental care provided through DoD to medal of honor recipients and their dependents.
Subtitle A—Senior Health Care	**Subtitle C- Health Care Programs for Medicare-Eligible DoD Beneficiaries**	**Subtitle B—Senior Health Care**
Sec. 731. Permanent Authority for Certain Pharmaceutical Benefits. Authorizes a specific pharmacy benefit for eligible beneficiaries of the military health care system, including those who are Medicare-eligible. Authorizes expansion of the national mail-order and retail pharmacy networks to include Medicare-eligible beneficiaries without requiring an enrollment fee or deductible. This provision would phase out the current BRAC pharmacy benefit.	**Sec. 721. Implementation of TRICARE Senior Pharmacy Program.** Authorizes establishment of the TRICARE Senior Pharmacy Program. This program will provide Medicare-eligible uniformed services beneficiaries the same pharmacy benefit currently available to other military health care beneficiaries (mail-order, TRICARE retail network and non-network providers and MTF pharmacies). No enrollment fee is required – same co-pays as other beneficiaries have. Requires participation in Medicare Part B. Allows beneficiary to choose a non-network provider. Authorizes increase of $94 million to Defense Health Budget for pharmacy benefit.	**Sec. 711. Implementation of TRICARE Senior Pharmacy Program.** Authorizes establishment of the TRICARE Senior Pharmacy Program effective April 1, 2001. This program will provide Medicare-eligible uniformed services beneficiaries the same pharmacy benefit currently available to other military health care beneficiaries (mail-order, TRICARE retail network and non-network providers and MTF pharmacies). No enrollment fee is required – same co-pays as other beneficiaries have. Requires participation in Medicare Part B after April 1, 2001 - but does allow those who did not enroll in Part B before April 1, 2002 to still participate. Allows beneficiary to choose a non-network provider – with a 25% copayment and a $150 deductible. Grandfathers all BRAC participants. Authorizes increase of $94 million to Defense Health Budget for pharmacy benefit.

Sec. 701. Conditions for Eligibility for CHAMPUS Upon the Attainment of 65 Years of Age. a) Makes Medicare-eligible beneficiaries eligible for TRICARE (Prime and Standard), provided they are enrolled in BOTH Medicare Part A and Part B, i.e., • eligible for TRICARE Standard as second payer to Medicare (and any other supplemental coverage), with no enrollment fee • eligible to enroll in TRICARE Prime for the same $230 per person annual enrollment fee paid by retirees under 65 (b) Changes the end date of the TRICARE Senior Prime demonstration program to December 31, 2002 (vice 2005, as originally proposed) The effective date for (a) and (b) would be Oct 1, 2001. **(This provision would only be in effect until Oct. 1, 2003)**	**Sec. 724. Extension of TRICARE Senior Supplement Program.** Extends TRICARE Senior Supplement program for one year.	**Sec. 712. Conditions for Eligibility for CHAMPUS and TRICARE Upon the Attainment of 65 Years of Age; Expansion and Modification of Medicare Subvention Project** a) Makes Medicare-eligible beneficiaries (due to age OR disability) eligible for TRICARE (Prime and Standard), provided they are enrolled in BOTH Medicare Part A and Part B, i.e., • eligible for TRICARE Standard as second payer to Medicare (and any other supplemental coverage), with no enrollment fee • eligible to enroll in TRICARE at military hospitals with no enrollment fee. (Conferees directed SecDef to use MacDill 65 program as a model – which empanels beneficiaries to a MTF primary care provider – but also utilizes civilian Medicare health care providers with TRICARE as second payer) • Beneficiaries pay no copayments or deductibles. This provision is effective October 1, 2001 and is permanent. Changes the end date of the TRICARE Senior Prime demonstration program to December 31, 2002. Authorizes $70 million for calendar year 2001 for continuation of Senior Prime. Continuation of TRICARE Senior Prime beyond this date is contingent upon SecDef and Sec HHS jointly developing and implementing program terms and conditions

		fair and equitable to both sides; providing a report to Congress; and subsequent legislation by Congress. SecDef to submit a plan for universal, continuous enrollment of all eligible beneficiaries beginning 1 Oct. 2001. Through this enrollment system, beneficiaries select how they will receive health care services (TRICARE standard or TRICARE Prime)
Sec. 741. Studies of Accrual Financing for Health Care for Military Retirees. Directs SecDef to conduct two studies, one by DoD, and one by an independent entity, to evaluate the potential of revising the financing of the military medical benefit for retirees through an accrual based system.	**Sec. 732. Study of Accrual Financing for Health Care for Military Retirees.** Directs SecDef to conduct a study to evaluate the potential of revising the financing of the military medical benefit for retirees through an accrual-based system. The study is to be conducted by an independent organization with expertise in financial programs, retirement systems, actuarial methodologies and health care financing. Authorizes an additional $2 million for this study.	**Sec. 713. Accrual Funding for Health Care for Medicare-Eligible Retirees and Dependents.** Establishes an accrual funding mechanism (to be known as the DoD Medicare-Eligible Retiree Health Care Fund) to finance, on an actuarially sound basis, DoD's liabilities for retirees health care programs for Medicare-eligible beneficiaries. Directs SecDef to conduct a study using an independent entity to develop strategies for determining the periodicity and amount of payments from the DoD Medicare-Eligible Retiree Health Care Fund. Results of the study are to be reported to Congress by Feb 8, 2001.
Subtitle B—TRICARE Program	**Subtitle B—TRICARE Program**	**Subtitle C—TRICARE Program**
Sect. 714. Improvement of Access to Health Care Under the TRICARE Program. Does not allow SecDef to require any beneficiary in TRICARE Standard to have to obtain a non-availability statement from an MTF or a specialized treatment facility unless: • SecDef demonstrates significant cost avoidance for specific procedures at the affected MTF; • SecDef determines a specific procedure must be maintained at a MTF in order to ensure proficiency levels of practitioners at that facility; • The lack of non-availability statement data would significantly interfere with contract administration Provision to take effect October 1, 2001	**Sect. 739. Improvement of Access to Health Care Under the TRICARE Program.** Does not allow SecDef to require any beneficiary in TRICARE Standard to have to obtain a non-availability statement from an MTF or a specialized treatment facility unless: • SecDef demonstrates significant cost avoidance for specific procedures at the affected MTF; • SecDef determines a specific procedure must be maintained at a MTF in order to ensure proficiency levels of practitioners at that facility; • The lack of non-availability statement data would significantly interfere with contract administration	**Sect. 739. Improvement of Access to Health Care Under the TRICARE Program.** Does not allow SecDef under new TRICARE contracts to require any beneficiary in TRICARE Standard to have to obtain a non-availability statement from an MTF or a specialized treatment facility unless: • SecDef demonstrates significant cost avoidance for specific procedures at the affected MTF; • SecDef determines a specific procedure must be maintained at a MTF in order to ensure proficiency levels of practitioners at that facility; The lack of non-availability statement data

		would significantly interfere with contract administration
Sect. 711. Additional Beneficiaries under TRICARE Prime Remote Program in CONUS. Expands TRICARE Prime Remote to uniformed services personnel and to family members of active duty personnel who qualify for Prime Remote.	**Sect. 711. Additional Beneficiaries under TRICARE Prime Remote Program in CONUS.** Expands TRICARE Prime Remote to all uniformed services personnel and to family members of active duty personnel who qualify for Prime Remote.	**Sect. 722. Additional Beneficiaries under TRICARE Prime Remote Program in CONUS.** Expands TRICARE Prime Remote to all uniformed services personnel and to family members of active duty personnel who qualify for Prime Remote.
Sec. 713. Improvement in Business practices in the Administration of the TRICARE Program. Directs SecDef to complete implementation of improved health care business practices no later than Oct. 1, 2002. Systemic changes necessary to achieve improved business practices and increased beneficiary and provider satisfaction are to be implemented by Oct. 1, 2002.	**Sec. 713. Modernization of TRICARE Business and Increases of Use in MTFs.** Directs SecDef to complete a plan for implementation of improved health care business practices no later than March 15, 2001 and to complete implementation by October 1, 2001. Also establishes improvement benchmarks for TRICARE in the area of portability; requires SecDef to simplify and Internet-enable critical administrative processes; and authorizes DoD to work with a managed care support contractor to build an open architecture model administration system in one TRICARE region. Also provides an increase of $134.5 million to Defense Health Budget to be used solely for the purpose of maximizing the use of MTFs: • $85.5 million to provide additional support staff to primary care providers in MTFs; • $20 million to support procurement of a local appointing and scheduling system; • $29 million to support local customer service and support initiatives Planning and installation of local appointing and scheduling and customer service operations are to be coordinated with regional managed care contractors in order to integrate and synchronize local systems with regional applications used by contractors.	**Sec. 723. Modernization of TRICARE Business and Increases of Use in MTFs.** Directs SecDef to complete a plan for implementation of improved health care business practices no later than March 15, 2001 and to complete implementation by October 1, 2001. Also establishes improvement benchmarks for TRICARE in the area of portability; requires SecDef to simplify and Internet-enable critical administrative processes; and authorizes DoD to work with a managed care support contractor to build an open architecture model administration system in one TRICARE region. Also provides an increase of $134.5 million to Defense Health Budget to be used solely for the purpose of maximizing the use of MTFs: • $85.5 million to provide additional support staff to primary care providers in MTFs; • $20 million to support procurement of a local appointing and scheduling system; • $29 million to support local customer service and support initiatives Planning and installation of local appointing and scheduling and customer service operations are to be coordinated with regional managed care contractors in order to integrate and synchronize local systems with regional applications used by contractors.

Sect. 579. Extension of TRICARE Managed Care Support Contracts (amendment introduced by Senator Warner). Extends current TRICARE managed care support contracts for additional four years subject to the following caveats: a) only if SecDef determines it is in best interest of government to do so; b) extensions shall be based on the price in the best and final offer for last year of existing contract as adjusted for inflation and other factors agreed to by contractor and government		**Sect. 724. Extension of TRICARE Managed Care Support Contracts (amendment introduced by Senator Warner).** Extends current TRICARE managed care support contracts for additional four years subject to the following caveats: c) only if SecDef determines it is in best interest of government to do so; extensions shall be based on the price in the best and final offer for last year of existing contract as adjusted for inflation and other factors agreed to by contractor and government
	Sec. 719. Report on Protections Against Health Care Provider Seeking Direct Reimbursement from Members of the Uniformed Services. Requires SecDef to provide a report by Jan. 31, 2001 to SASC and HASC on ways to discourage or prohibit TRICARE health care providers from seeking inappropriate direct reimbursement from military beneficiaries.	**Sec. 725. Report on Protections Against Health Care Provider Seeking Direct Reimbursement from Members of the Uniformed Services.** Requires SecDef to provide a report by Jan. 31, 2001 to SASC and HASC on ways to discourage or prohibit TRICARE health care providers from seeking inappropriate direct reimbursement from military beneficiaries.
	Sec. 720. Disenrollment Process for TRICARE Retiree Dental Program. Authorizes SecDef to permit retirees enrolled in Retiree Dental Plan to disenroll under certain circumstances to include: 1) case where member who is also Federal employee, is transferred overseas; 2) when enrollee provides medical documentation of an illness or injury which precludes him/her from getting dental care; 3) case where severe financial hardship would result if member had to remain enrolled; and 4) any other circumstance Secretary considers appropriate.	**Sec. 726. Voluntary Termination of Enrollment in TRICARE Retiree Dental Program.** Provides for 30-day disenrollment grace period. Also authorizes SecDef to permit retirees enrolled in Retiree Dental Plan to disenroll after the 30-day grace period under certain circumstances to include: • case where member who is also Federal employee, is transferred overseas; • when enrollee provides medical documentation of an illness or injury which precludes him/her from getting dental care; • case where severe financial hardship would result if member had to remain enrolled; and • any other circumstance Secretary

		considers appropriate.
	Sec. 714. Claims Processing. Requires SecDef to implement changes to TRICARE claims processing to include: • replacing the Health Care Service Record (HCSR) with the TRICARE Encounter Data System; • separating the HCSR and claims payment components of the claims adjudication and payment system; • requiring high volume TRICARE providers to submit claims by electronic means; • increasing use of automated voice response unit systems for determining claims status. Also provides increase of $3.6 million to Defense Health Budget to be used solely for implementing TRICARE Encounter Data system as a replacement for the HCSR.	**Sec. 727 Claims Processing.** Requires SecDef to implement changes to TRICARE claims processing to include: • replacing the Health Care Service Record (HCSR) with the TRICARE Encounter Data System; • separating the HCSR and claims payment components of the claims adjudication and payment system; • requiring high volume TRICARE providers to submit claims by electronic means; • increasing use of automated voice response unit systems for determining claims status. • Processing 50% of all claims by electronic means Also provides increase of $3.6 million to Defense Health Budget to be used solely for implementing TRICARE Encounter Data system as a replacement for the HCSR.
	Sec. 715. Prohibition Against Requirement for Prior Authorization for Certain Referrals; Report on Non-Availability of Health Care Statements. Prohibits SecDef from requiring any TRICARE managed care support contractors to establish prior approval requirements among network providers.	**Sec. 728. Prior Authorization for Certain Referrals and Non-Availability of Health Care Statements.** Prohibits SecDef from requiring any TRICARE managed care support contractors to establish prior approval requirements

		among network providers. (Applies to new contracts entered into after enactment of this Act.) Comptroller General to submit a report to Congress by Feb 1, 2001 on financial and management implications of eliminating requirement to obtain NAS.
		Subtitle D – Demonstration Projects
	Sec. 704 – Demonstration Project for Expanded Access to Mental Health Counselors. Directs SecDef to conduct a 2-year demonstration project in one TRICARE region to determine the effect of increasing access to certified professional mental health counselors by removing the requirement for physician referral prior to engaging a counselor under TRICARE.	**Sec. 731 – Demonstration Project for Expanded Access to Mental Health Counselors.** Directs SecDef to conduct a 2-year demonstration project in one TRICARE region to determine the effect of increasing access to certified professional mental health counselors by removing the requirement for physician referral prior to engaging a counselor under TRICARE.
	Sec. 705. Teleradiology Demonstration Project. Directs SecDef to implement a teleradiology demonstration project to increase efficiency of operations and coordination between outlying clinics and major MTFs. This initiative is to be demonstrated at a multi-specialty tertiary care MTF with an university medical school affiliation, and would link at least 5 geographically –dispersed Army, Navy and Air Force clinic as well as remote DVA and Coast Guard health clinic. Once implemented, the initiative will be unique in having all but one of the medical facilities in a single TRICARE region using a common Composite Health Care System data million platform. The HASC authorizes an increase of $1.5 million in FY 2001 to fund the demonstration.	**Sec. 732. Teleradiology Demonstration Project.** Directs SecDef to implement a teleradiology demonstration project to increase efficiency of operations and coordination between outlying clinics and major MTFs. This initiative is to be demonstrated at several multi- specialty tertiary care MTFs with university medical school affiliations. One such site would link at least 5 geographically –dispersed Army, Navy and Air Force clinic as well as remote DVA and Coast Guard health clinic. Another site shall be in an underserved rural geographic area. Once implemented, the initiative will be unique in having all but one of the medical facilities in a single TRICARE region using a common Composite Health Care System data million platform.
Sec. 740. Health Care Management Demonstration Program. Directs SecDef to conduct a test of two models to improve health care delivery in the Defense Health Program. One		**Sec. 733. Health Care Management Demonstration Program.** Directs SecDef to conduct a test of two models to improve health care delivery in the

would study alternative delivery policies, processes, organizations and technologies; the second for studying long term disease management. SecDef is to implement each of these concepts in at least one site in FY 2001, and report to SASC and HASC not later than Jan 31, 2002 on the desirability and feasibility of incorporating these programs throughout the entire military health care system.		Defense Health Program. One would study alternative delivery policies, processes, organizations and technologies; the second for studying long term disease management. SecDef is to implement each of these concepts in at least one site not later than 180 days after enactment of this Act, and the test will terminate on Dec. 31, 2001. SecDef is to report to Congress by Mar 15, 2002, on the desirability and feasibility of incorporating these programs throughout the entire military health care system. Authorizes $6 million for this demonstration program.
	Subtitle E- Joint Initiatives with Department of Veterans Affairs	**Subtitle E- Joint Initiatives with Department of Veterans Affairs**
	Sec. 738. VA/DoD Sharing Agreements for Health Services. Requires SecDef to give full force and effect to any sharing agreement between DoD and VA health care facilities. Also requires SecDef to review all sharing agreements over the next year.	**Sec. 741. VA/DoD Sharing Agreements for Health Services.** Requires SecDef to give full force and effect to any sharing agreement between DoD and VA health care facilities. Also requires SecDef to review all sharing agreements over the next year.
Sec. 721. Tracking Patient Safety in Military and Veterans Health Care Systems. Directs enhanced cooperation between DoD and VA in the area of patient safety. The two agencies are directed to work to develop a common set of patient safety indicators and to provide for centralized tracking of those indicators.	**Sec. 733. Tracking Patient Safety in Military Medical Treatment Facilities.** Requires SecDef to implement a system of indicators, standards and protocols necessary to track patient safety.	**Sec. 742. Processes for Patient Safety in Military and Veterans Health Care Systems.** Directs enhanced cooperation between DoD and VA in the area of patient safety. The two agencies are directed to work to develop a common set of patient safety indicators and to provide for centralized tracking of those indicators.
Sec. 722. Pharmaceutical Identification Technology. Directs DoD and VA to jointly develop a plan to bar code pills and explore a bar code capability for the mail-order pharmacy program.	**Sec. 734. Pharmaceutical Identification Technology.** Directs just DoD to develop a plan to bar code pills and explore a bar code capability for the mail-order pharmacy program.	**Sec. 743. Cooperation in Developing a Pharmaceutical Identification Technology.** Directs DoD and VA to jointly develop a plan to bar code pills and explore a bar code capability for the mail-order pharmacy

		program. When common pharmaceuticals are used by both health care systems, the bar codes for these drugs shall be identical.
	Subtitle F- Other Matters	**Subtitle F- Other Matters**
	Sec. 735. Management of Vaccine Immunization Program. Strengthens Congressional oversight of DoD's Anthrax Vaccine Immunization Program (AVIP) by: • requiring SecDef to keep track of separations from service resulting from refusal to get vaccine; • requiring clear guidance for emergency essential civilian personnel participating in AVIP; • requiring SecDef to put uniform medical and administrative exemptions into regulation; • improving the system for the monitoring of adverse reactions including "active surveillance" and long-term follow-up; • requiring SecDef to develop a plan of action for modernizing all force protection immunizations and avoid using a single manufacturer wherever possible; • requiring reports on financial and overall program management	**Sec. 751. Management of Vaccine Immunization Program.** Strengthens Congressional oversight of DoD's Anthrax Vaccine Immunization Program (AVIP) by: • requiring SecDef to keep track of separations from service resulting from refusal to get vaccine; • requiring clear guidance for emergency essential civilian personnel participating in AVIP; • requiring SecDef to put uniform medical and administrative exemptions into regulation; • improving the system for the monitoring of adverse reactions including "active surveillance" and long-term follow-up.
Sec. 712. Elimination of CoPayments for Immediate Family. Eliminates copayments for immediate family members of active duty service members enrolled in TRICARE Prime.	**Sec. 712. Elimination of CoPayments for Immediate Family.** Eliminates copayments for immediate family members of active duty service members enrolled in TRICARE Prime.	**Sec. 752. Elimination of CoPayments for Immediate Family.** Eliminates copayments for immediate family members of active duty service members enrolled in TRICARE Prime. (Does not apply to prescription copayments – these will still remain.) This provision to take effect 180 days after enactment (and is not retroactive).
Sec. 723 Medical Informatics. Directs SecDef to include two additional sections in the medical informatics report required by the FY 2000 Defense Authorization Act. The recommended sections include a requirement to report on the progress of growth in medical informatics, and to report on how the TRICARE program and the VA health care program can use medical information technology to raise standards of treatment. Also directs that $64 million of Defense Health Program be spent on a computerized patient record system and $9 million be spent on an integrated pharmacy system in FY		**Sec. 753. Medical Informatics.** Directs SecDef to include two additional sections in the medical informatics report required by the FY 2000 Defense Authorization Act. The recommended sections include a requirement to report on the progress of growth in medical informatics, and to report on how the TRICARE program and the VA health care program can use medical information technology to raise standards of treatment. Also directs that $64 million of Defense Health Program be spent on a computerized

2001.		patient record system and $9 million be spent on an integrated pharmacy system in FY 2001.
Sec. 739. Patient Care and Management System. Directs SecDef to implement a patient care reporting and management system in the military health care system. This system is to identify, track and report on errors and safety problems in the military medical system. Also directs development of a process to study occurrence of errors, identify systems factors contributing to occurrences, and provide for corrective actions throughout the military health care system.		**Sec. 754. Patient Care and Management System.** Directs SecDef to implement a patient care reporting and management system in the military health care system. This system is to identify, track and report on errors and safety problems in the military medical system. Also directs development of a process to study occurrence of errors, identify systems factors contributing to occurrences, and provide for corrective actions throughout the military health care system.
Sec. 742. Augmentation of Army Medical Department by Reserve Officers of the Public Health Service Corps. Permits Secretary of the Army and the Secretary of HHS to enter into an agreement to conduct a program under which officers o f the Public Health Service Corps Inactive Reserve may be detailed to augment the Army Medical Department, subject to existing legislative authorities.		**Sec. 755. Augmentation of Army Medical Department by Detailing Reserve Officers of the Public Health Service Corps.** Permits Secretary of the Army and the Secretary of HHS to enter into an agreement to conduct a program under which officers o f the Public Health Service Corps Inactive Reserve may be detailed to augment the Army Medical Department, subject to existing legislative authorities.
Sec. 742 Privacy of DoD Medical Records. Directs SecDef to create a Blue Ribbon Advisory Panel on DoD policies regarding the privacy of medical records.		**Sec. 756. Privacy of DoD Medical Records.** Directs SecDef to report to Congress on a comprehensive plan to improve privacy protections for DoD medical records, consistent with the Health Insurance Portability and Accountability Act of 1996. Directs SecDef to issue interim regulations to expedite implementation of this provision and allow for reasonable use of medical records for certain circumstances, including national security, law enforcement, patient treatment and payment for health care services.
Sec. 715. Enhances access to TRICARE in rural states by increasing the maximum allowable charge by physicians in rural areas.	**Sec. 716. Authority to Establish Special Locality-Based Reimbursement Rate; Reports.** Authorizes SecDef to establish higher rates for reimbursement for services in some localities under certain condition.	**Sec. 757. Authority to Establish Special Locality-Based Reimbursement Rate; Reports.** Authorizes SecDef to establish higher rates for reimbursement for services in some localities under certain condition. Conferees want DoD to focus on rural areas in particular and to focus on resolving provider participation

		issues.
	Sec. 717. Reimbursement for Certain Travel Expenses. Authorizes SecDef to reimburse TRICARE beneficiaries for their reasonable expenses incurred while traveling to a referral more than 100 miles from where they normally receive primary care services. Authorizes an additional $15million increase to the Defense Health Budget for this purpose.	**Sec. 758. Reimbursement for Certain Travel Expenses.** Authorizes SecDef to reimburse TRICARE beneficiaries for their reasonable expenses incurred while traveling to a referral more than 100 miles from where they normally receive primary care services.
	Sec. 718. Reduction of Catastrophic Cap. Reduces catastrophic cap for retirees in TRICARE Standard from $7500 to $3,000. Authorizes an additional $32 million for this purpose	**Sec. 759. Reduction of Cap on Payments.** Reduces catastrophic cap for retirees in TRICARE Standard from $7500 to $3,000. Authorizes an additional $32 million for this purpose.
	Sec. 731. Training in Health Care Management and Administration. Requires SecDef to provide a report to SASC and HASC on the progress of FY 96 NDAA provision 715 which increased the number of senior management positions requiring professional management and administration experience. Sec. 715 also directed SecDef to provide a report on the training of DoD health care managers.	**Sec. 760. Training in Health Care Management and Administration.** Requires SecDef to provide a report to SASC and HASC on the progress of FY 96 NDAA provision 715 which increased the number of senior management positions requiring professional management and administration experience. Sec. 715 also directed SecDef to provide a report on the training of DoD health care managers. SecDef to ensure that senior managers involved in leading and managing DoD health care delivery program are provided all possible professional management and administrative opportunities to increase their ability to succeed in this dynamic environment.

	Sec. 736. Study on Feasibility of Sharing Biomedical Research Facility. Recommends the Army conduct a feasibility study for a medical research facility to be shared by Tripler Army medical center, VA and the University of Hawaii that includes a clinical research center, educational, academic and laboratory research space to better leverage its limited research funds. Authorizes an additional $2.5 million for this study.	**Sec. 761. Study on Feasibility of Sharing Biomedical Research Facility.** Recommends the Army conduct a feasibility study for a medical research facility to be shared by Tripler Army medical center, VA and the University of Hawaii that includes a clinical research center, educational, academic and laboratory research space to better leverage its limited research funds. Air Force to conduct a similar study on Little Rock Medical Facility sharing a biomedical research facility with DVA and the School of Medicine at the University of Arkansas.
	Sec. 740. Study on Comparability of Coverage for Physical, Speech and Occupational Therapies. Requires SecDef to conduct a study comparing coverage and reimbursement for physical, speech and occupational therapies under TRICARE and under FEHBP. Study is to examine: • Types of services covered • Whether prior authorization is required; • Reimbursement limits; • Whether services are covered on both inpatient and outpatient basis. Study is to be submitted to Congress by March 31, 2001.	**Sec. 762. Study on Comparability of Coverage for Physical, Speech, and Occupational Therapies.** Requires SecDef to conduct a study comparing coverage and reimbursement for physical, speech and occupational therapies under TRICARE and under Medicare and FEHBP. Study is to examine: • Types of services covered • Whether prior authorization is required; • Reimbursement limits; • Whether services are covered on both inpatient and outpatient basis. Study is to be submitted to Congress by March 31, 2001.
Provisions not Adopted	**Provisions not Adopted**	
	Sec. 725. Extension of TRICARE Senior Prime Demonstration Program. Extends the TRICARE Senior Prime Program to December 31, 2003. (Subsequently amended by Taylor to the following: • TRICARE Senior Prime will be expanded to any site with a full range of comprehensive health care services by 2006. • TRICARE Senior Prime will be made a permanent program • Permits Medicare reimbursement on a fee-for-service basis • Removes restriction on whether TRICARE Prime enrollee has civilian or military PCM • Provides Medigap insurance protection for those who	

	disenroll from TRICARE Senior Prime Implements utilization review procedures for TRICARE Senior Prime program.	
	Sec. 723. Extended Coverage Under FEHBP. Extends FEHBP demonstration for one year and requires SecDef to take necessary actions to encourage participation in the program to its full-authorized enrollment level of 66,000. Committee encourages SecDef to select additional site where at least 5,000 military retirees are served by multiple military health care installations (both VA and DoD facilities). Committee also wants additional site to have both urban and rural populations. SecDef is also to make sure all FEHBP marketing materials may clear to potential enrollees that alternative health care insurance 9ie Medigap plans) will be available if demonstration concludes without being made permanent.	
	Sec. 722 – Study on Health Care Options for Medicare-eligible Military retirees. Requires SecDef to conduct a study on alternatives for providing continues health care benefits for Medicare-eligible military retirees. Study is to be conducted by a federally funded research and development center (FFRDC), and SecDef is to appoint an independent committee to advise him and the FFRDC on the conduct of the study. An additional $2 million is authorized for this study.	
Sec. 738. Use of Information Technology for Enhancement of Delivery of Administrative Services under the Defense Health Program. Directs SecDef to implement in at least one TRICARE region, a managed care support contract using commercially available internet-based systems and products to assist in simplifying administrative processes in the TRICARE program. The recommended program would comply with patient confidentiality and security requirements and incorporate date requirements currently used in the marketplace, to include those used by Medicare and/or commercial insurers. This effort is to include such areas as marketing, enrollment, beneficiary and provider education, appointment setting and claims processing.		

	Funding for the Defense Health Program. The Committee expressed concern about the continued underfunding of the Defense Health Budget by DoD and encourages SecDef to ensure the health care system is funded to a level that not only provides for continuous patient care, but that also invests in the infrastructure to ensure long-term effectiveness of the system. Also encourages SecDef to continue to foster the active participation of DoD's senior uniformed leaders in important decisions affecting the management of the military health care system.	
	Preventive Health Care. Directs SecDef to submit a report to Congress by March 1, 2001 on steps taken to improve the implementation of the "Put Prevention into Practice" initiative.	
	Report on Computer-based Patient Record and Medical Records Tracking System. Directs SecDef to provide an annual report (starting March 1, 2001) to Congress on the progress of developing a Government Computer-Based Patient Record (GCPR). Directs Comptroller General of the US to evaluate the program with a focus on the agencies' plans for meeting milestones, including budget and cost estimates and issues relating to privacy, data quality and security. Evaluation due to Congress by March 1,2001. Also directs SecDef to report to Congress by March 31, 2001 on the progress of the Medical Records Tracking System (MRTS), and on interim measures to assure all hospital and medical records of service members are easily identified.	
	Report on Mandatory Enrollment for TRICARE Beneficiaries. Directs SecDef to conduct a study of the benefits to be gained by requiring all TRICARE beneficiaries enroll in the TRICARE program. The study should, at the minimum, 1. analyze the benefits of mandatory enrollment in Prime or risk losing all access to MTFs; 2. the value of requiring all non-active duty beneficiaries to pay a small enrollment fee to enroll in of the TRICARE programs.	

	Study is to be submitted by March 31, 2001 to Congress.	
Consultation with Schools of Pharmacy and Nursing. Directs military services to implement a program in which military treatment facilities and clinics would partner with local pharmacy and nursing schools to incorporate the full range of health care professional resources in health care endeavors.		
Financial Assistance for those Beneficiaries Requiring Animal Assistance. Directs SecDef to study and report to the HASC and SASC on the requirements for animal assistance for dependents of military personnel whose medical conditions may require such assistance. The report should include an assessment of the economic impact to families of obtaining animals for such purposes as "seeing eye" assistance and other medical conditions. The report should include an analysis of the current benefit coverage by DoD, and a proposal for coverage of such assistance.		
Health Care Benefits for Retirees Living Overseas. Directs SecDef to study and report to the HASC and SASC by March 12, 2001 on the desirability and feasibility of providing health care benefits to military retirees living outside the U.S. The study is to include an assessment of the numbers of retirees permanently residing overseas, an assessment of how many have returned to their home of origin, and options for providing health care benefits to retirees overseas.		
Implementation of DoD and VA Sharing Initiatives. Directs SecDef and SecVA to develop a plan and report to the HASC and SASC by Jan 31, 2001 on the formation of problem solution groups and regional liaisons to facilitate sharing opportunities. Issues to be addressed should include reimbursement and payment, joint contracting, data commonality and any other issues inhibiting sharing of resources.		
Notification of Persons Affected by Unanticipated		

Adverse Outcomes of Medical Care. Directs SecDef to review process for identifying serious medical errors and notifying affected patients or their families of such error events. The review shall include the mandatory reporting system used in DoD's 500 hospitals and clinics as described in the Report of the Quality Interagency Coordination Task Force to the President, dated Feb. 2000. SecDef shall report to HASC and SASC by March 1, 2001 on current notification process and any additional requirements the Secretary deems necessary after such review.		
Special Pays for Military Health Care Professionals. Directs SecDef to conduct a review and report to HASC and SASC by March 1, 2001 on the adequacy of special pays and bonuses for medical corps officers and other health care professionals.		

LIST OF REFERENCES

1. McCain, John, U.S. Senate, "*Honoring Health Care Commitments to Service Members Past and Present Act of 2000*," Testimony to Senate, Washington, D.C., January 27, 2000.

2. Congressional Budget Office, *"Budget Options For National Defense,"* Washington, D.C., March, 2000.

3. Maassen, Leland, and Whipple, David, "*A History of the Military Dependent Medical Care Programs*," Naval Postgraduate School, CA, August 1975.

4. Burrelli, David F., "*Military Health Care: The Issue of 'Promised' Benefits,"* CRS Report to Congress, Washington, D.C., February 10, 2000.

5. Maassen, Leland R., "*The Civilian Health and Medical Program for the Uniformed Services (CHAMPUS)*," Thesis, M102, Naval Postgraduate School, CA, June, 1975.

6. Act of 5 July 1884, Army Appropriations, "*Statutes At Large*," Chap. XXIII, Pg. 217. 1884.

7. An Act to Reorganize and Improve the Efficiency of the Personnel of the Navy and Marine Corps of the United States, "*Statutes At Large*," Chap. XXX, Pg. 423. 1899.

8. Department of Defense Directive, "*Dependent's Medical Care*," NUMBER 6010.4, Washington, D.C., April 25, 1962.

9. Department of Defense Instruction, "*Identification (ID) Cards for Members of the Uniformed Services, Their Dependents, and other Eligible Individuals*," NUMBER 1000.13, Washington, D.C., December 5, 1997.

10. Public Law 51, "*An Act to Provide for the Expansion of Navy Medical Facilities*," May 10, 1943.

11. Public Law 84-569, "*Dependent's Medical Care Act*," June 7, 1956.

12. Public Law 89-614, "*Military Medical Benefits Amendments of 1966*," September 30, 1966.

13. Heinzelman, Dwight O., "*The Evolution of the Military Health Care Benefit (MHCB): The Scope of the Changes and the Principle Drivers Behind Them,*" Thesis, H42372, Naval Postgraduate School, CA, March, 1997.

14. Carroll, Eugene J., "*Pentagon Pursues Implausible Scenario,*" Newsday, May 22, 1997.

15. Lane, Michael and Melody, Brendan T., "*The Impact of Pay on Navy Physician Retention in a Health Care Reform Environment,*" Thesis, L2575, Naval Postgraduate School, CA, March, 1998.

16. Assistant Secretary of Defense for Health Affairs, "*Defense Health Program, FY2001 President's Budget,*" FY 2001 Budget Estimates, Washington, D.C., February, 2000.

17. Budget Of The United States Government, Fiscal Year 2001, "*Defense Health Program,*" Operations And Maintenance, Appendix, PP 264-266, Washington, D.C., February, 2000.

18. Freedburg, Sydney J., Jr., "*The Outlook for Military Health Care Reform Debated,*" National Journal, February 25, 2000.

19. Backhus, Stephen P., "*Defense Health Care, Observations on Proposed Benefit Expansion and Overcoming TRICARE Obstacles,*" General Accounting Office, Washington, D.C., March 15,2000.

20. The Air Force Association, "*It's Showdown Time on Tricare,*" Air Force Magazine, vol. 83, No. 4, April 2000.

21. Clark, Vern, Chief of Naval Operations, "*Assuming the Watch,*" Speech, Washington, D.C., July 23, 2000.

22. Leon, Rudy de, U.S. Senate, Committee On Armed Services, Subcommittee on Personnel, "*The Military Health System,*" A Joint Overview Statement, Panel II, Washington, D.C., March 2, 2000.

23. Soule, Robert R., U.S. Senate, Committee On Armed Services, Subcommittee on Personnel, "*The Military Health System,*" A Joint Overview Statement, Panel II, Washington, D.C., March 2, 2000.

24. Sears, James H., U.S. Senate, Committee On Armed Services, Subcommittee on Personnel, "*The Military Health System,*" A Joint Overview Statement, Panel III, Washington, D.C., March 2, 2000.

25. Bailey, Sue, U.S. Senate, Committee On Armed Services, Subcommittee on Personnel, "*The Military Health System,*" A Joint Overview Statement, Panel III, Washington, D.C., March 2, 2000.

26. Telephone conversation between Whitmeyer, Antoinette, CDR, USUHS, and the author, October 10, 2000.

27. Eberhart, David, "*Veterans Still Steamed Over Cohen Retreat on Health Care,*" Stars and Stripes, September 7, 2000.

28. Wilson, George C., "*New Military Health Benefits Could Cost $116 Billion,*" National Journal, September 5, 2000.

29. Ferguson, Lantie, "*Health Care for Aging Vets: The Price of a Promise,*" Congressional Quarterly, April 29, 2000.

30. Assistant Secretary of Defense for Public Affairs, "*Department of Defense Budget for FY2001,*" DefenseLink, Washington, D.C., February 7, 2000.

31. Caruso, Lisa, "*Republicans Plot 2001 Budget Strategy,*" CongressDaily, January 31, 2000.

32. Eisman, Dale, "*Older Military Retirees Set to Get Health Insurance Back,*" Norfolk Virginian-Pilot, Norfolk, VA, September 9, 2000.

33. U.S. House of Representatives, *"H.R. 2966, Keep Our Promise To America's Military Retirees Act,"* Washington, D.C., September 28, 1999.

34. U.S. House of Representatives, *"H.R. 3573, Keep Our Promise To America's Military Retirees Act,"* Washington, D.C., February 2, 2000.

35. Congressional Budget Office, Cost Estimate, "*H.R. 2966, Keep Our Promise To America's Military Retirees Act,*" Washington, D.C., March 28, 2000.

36. Congressional Budget Office, Cost Estimate, *"H.R. 3573, Keep Our Promise To America's Military Retirees Act,"* Washington, D.C., March 29, 2000.

37. Budget Bulletin, "*Defense Health Program: Big Problems, Even Bigger Costs,*" Washington, D.C., April 3, 2000.

38. Bearce, Lauri, *"How Does a Discharge Petition Work?"* TROA's Legislative Update, June 20, 2000.

39. National Military Veterans Alliance, U.S. Senate, Committee On Armed Services, Subcommittee on Personnel, *"The Military Health System,"* A Joint Overview Statement, Panel I, Washington, D.C., March 2, 2000.

40. Partridge, Charles C., U.S. Senate, Committee On Armed Services, Subcommittee on Personnel, *"The Military Health System,"* A Joint Overview Statement, Panel I, Washington, D.C., March 2, 2000.

41. Ferguson, Lantie, *"Four Bills on Retiree's Health Care Differ in Approach and Cost,"* Congressional Quarterly, April 29, 2000.

42. U.S. House of Representatives, *"H.R. 3655, Improved Medical Care for Troops and Retirees Act,"* Washington, D.C., February 15, 2000.

43. Congressional Budget Office, Cost Estimate, *"H.R. 3655, Improved Medical Care for Troops and Retirees Act,"* Washington, D.C., April 10, 2000.

44. U.S. House of Representatives, *"H.R. 4030, Enhancement of Military Benefits Act,"* Washington, D.C., March 16, 2000.

45. Congressional Budget Office, Cost Estimate, *"H.R. 4030, Enhancement of Military Benefits Act,"* Washington, D.C., May 10, 2000.

46. TROA Homepage, Bills of Interest, *"H.R. 4030,"* World Wide Web, September 26, 2000.

47. TROA Homepage, *"Bills of Interest,"* World Wide Web, September 26, 2000.

48. U.S. Senate, *"S. 2013, Honoring Health Care Commitments to Servicemembers Past and Present Act of 2000,"* Washington, D.C., January 27, 2000.

49. Ives, Nancy, *"McCain Introduces Landmark Military Retiree and Active Duty Health Care Reform Bill,"* John McCain Press Release, Washington D.C., January 27, 2000.

50. Wieczorek, Lauri, *"Coalition Testifies on Health Care,"* TROA's Legislative Update, March 3, 2000.

51. Ives, Nancy, *"McCain Urges More Comprehensive Approach to Military Health Care Return,"* John McCain Press Release, Washington D.C., February 24, 2000.

52. U.S. Senate, "S. *2087, Military Health Care Improvements Act of 2000,"* Washington, D.C., February 23, 2000.

53 Congressional Budget Office, Cost Estimate, "S. *2087, Military Health Care Improvements Act of 2000,"* Washington, D.C., May 1, 2000.

54. Ferguson, Lantie, "*Health Care for Aging Vets: The Promise of a Promise,*" Congressional Quarterly, April 29, 2000.

55. U.S. Senate, "*S. 2003, Keep Our Promise To America's Military Retirees Act,"* Washington, D.C., January 24, 2000.

56. Congressional Budget Office, Cost Estimate, "*S. 2003, Keep Our Promise To America's Military Retirees Act,"* Washington, D.C., March 29, 2000.

57. Cornick, Carter, " *Warner Introduces Strengthened Military Health Care Bill,"* John Warner Press Release, Washington, D.C., May 1, 2000.

58. U.S. Senate, "S. *2486, Military Health Care Improvements Act of 2000,"* Washington, D.C., May 1, 2000.

59. U.S. Senate, Committee Report, "*Senate Rpt. 106-298 Department of Defense Appropriation Bill, 2001,"* Defense Health Program, Washington, D.C., May 18, 2000.

60. U.S. Senate, Committee Report, "*Senate Rpt. 106-292 National Defense Authorization Act, 2001,"* Defense Health Program, Washington, D.C., May 12, 2000.

61. Daggett, Stephen, "*Appropriations For FY2001: Defense,*" CRS Report for Congress, RL30505, Congressional Research Service, Washington, D.C., October 11, 2000.

62. Wieczorek, Lauri, *"Budget Conferees Slash Reserve Fund,"* TROA's Legislative Update, April 14, 2000.

63. U.S. House of Representatives, "*Reserve Fund for Military Retiree Health Care,*" Concurrent Resolution on the Budget for Fiscal Year 2001, Sec. 218, Pp. 21,80,86. Washington, D.C., April 12, 2000.

64. Ferguson, Lantie, "*Decline in 'Space Available' Care Adds to Pressure for Prescription Benefit,*" Congressional Quarterly, April 29, 2000.

65. U.S. House of Representatives, Committee Report, "*House Rpt. 106-644 Department of Defense Appropriation Bill, 2001,*" Defense Health Program, Washington, D.C., May 25, 2000.

66. U.S. House of Representatives, Conference Report, "*House Rpt. 106-754 Making Appropriations For the Fiscal Year Ending September 30, 2001, And For Other Purposes,*" Defense Health Program, Washington, D.C., July 17, 2000.

67. Public Law 106-259, "*Department of Defense Appropriation Act, 2001,*" Washington, D.C., August 9, 2000.

68. U.S. House of Representatives, Committee Report, "*House Rpt. 106-616 Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001,*" Defense Health Program, Washington, D.C., May 12, 2000.

69. Congressional Budget Office, Cost Estimate, "*H.R. 4205, National Defense Authorization Act for Fiscal Year 2001,*" Washington, D.C., May 12, 2000.

70. TROA Homepage, Health Care Legislative Issues, "*Key NDAA Health Care Provisions,*" World Wide Web, November 20, 2000.

71. TROA Homepage, Legislative Updates, "*Permanent TRICARE-For-Life,*" World Wide Web, September 22, 2000.

72. Cohen, William, Secretary of Defense, "*Letter to the Chairman, Senate Armed Services Committee,*" Washington, D.C., August 7, 2000.

73. TROA Homepage, Legislative Initiatives, "*FY2001 National Defense Authorization Act (NDAA) Bill's Major Health Care Provisions,*" World Wide Web, September 26, 2000.

74. Wilson, George C., "*Key Senator Says Vets Likely to Get Lifetime Health Care,*" National Journal, September 18, 2000.

75. Congressional Budget Office, "*A Comparison of the Budgetary Effects for Two Proposals to Extend Health Care Benefits to Retirees of the Uniformed Services Who Are Age 65 and Older,*" Washington, D.C., October 11, 2000.

76. Congressional Budget Office, Pay-As-You-Go Estimate, "*H.R. 4205, An act to authorize appropriations for fiscal year 2001 for military activities of the Department of Defense for military construction, and for defense activities of the Department of Energy,*

to prescribe personnel strengths for such fiscal year for the Armed Forces, and for other purposes," Washington, D.C., October 26, 2000.

77. Towell, Pat, "*Coalition of Interests, Budget Surplus Won New Benefits for Military Retirees,*" Congressional Quarterly, October 28, 2000.

78. U.S. House of Representatives, Conference Report, "*House Rpt. 106-945 Enactment of Provisions of H. R. 5408, The Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001,*" Health Care Provisions, Washington, D.C., October 6, 2000.

79. Budget Bulletin, "*The Cost of Military Retiree Health Care,*" Washington, D.C., October 30, 2000.

80. Cragin, Maureen, and Vaart, Ryan, "*Keeping Faith with America's Veterans,*" Press Release, House Armed Services Committee, Floyd D. Spence, Chairman, Washington D.C., October 6, 2000.

81. Becker, Elizabeth, "*Congress Approves Plan to Insure Military Retirees,*" New York Times, Washington, D.C., October 13, 2000.

82. TROA Homepage, Key Legislation Cosponsors, "*TRICARE-For-Life (Defense Authorization Act) Bill #H. R. 4205,*" World Wide Web, November 11, 2000.

83. Telephone conversation between Whitmeyer, Antoinette, CDR, USUHS, and the author, November 29, 2000.

84. Kerrey, Robert, U. S. Senator from Nebraska, "*The Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001,-- Conference Report (Senate- October 12, 2000),*" Testimony, S10365, October 12, 2000.

85. Warner, John, U. S. Senator from Virginia, "*The Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001,-- Conference Report (Senate- October 12, 2000),*" Testimony, S10368, October 12, 2000.

86. Gramm, Phil, U. S. Senator from Texas, "*The Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001,-- Conference Report (Senate- October 12, 2000),*" Testimony, S10369, October 12, 2000.

87. Gramm, Phil, U. S. Senator from Texas, "*The Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001,-- Conference Report (Senate- October 12, 2000),*" Testimony, S10371, October 12, 2000.

THIS PAGE INTENTIONALLY LEFT BLANK

INITIAL DISTRIBUTION LIST

1. Defense Technical Information Center 2
   8725 John J. Kingman Road, Ste 0944
   Fort Belvoir, VA 22060-6218

2. Dudley Knox Library 2
   Naval Postgraduate School
   411 Dyer Road
   Monterey, California 93943-5101

3. Professor Richard B. Doyle, Code SM/DY 1
   Naval Postgraduate School
   Monterey, CA 93943

4. Professor Frank J. Barrett, Code SM/BR 1
   Naval Postgraduate School
   Monterey, CA 93943

5. LT Timothy R. Richardson 1
   2430 N. Fairmont Dr.
   Hanford, CA 93230